General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 7 Kings Drive, CREWE, Cheshire, CW2 8HY

Pharmacy reference: 1098347

Type of pharmacy: Community

Date of inspection: 01/05/2024

Pharmacy context

This pharmacy is situated in a small parade of shops within a residential area of Crewe. The pharmacy dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines. It also provides the NHS Pharmacy First service, a minor ailments, seasonal flu vaccinations and a blood pressure check service.

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	1.2	Good practice	The pharmacy is good at recording and reviewing mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk.
		1.8	Good practice	The pharmacy team members have undertaken appropriate safeguarding training and are able to describe actions they have taken to safeguard vulnerable individuals.
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 is good at recording and regularly reviewing any mistakes that happen during the dispensing process. And it uses this information to help minimise any future risks and help make its services safer. Its team members understand their role in protecting vulnerable people. The pharmacy regularly seeks feedback from people who use the pharmacy. And it keeps its records up to date and in line with requirements.

Inspector's evidence

Standard operating procedures (SOPs) were available electronically on an e-learning portal and were assigned to team members to read depending on their roles. SOPs were grouped into bundles and the pharmacy manager kept a record of procedures that all team members had read. Other than the new team members who were in the process of reading the SOPs, all other team members were up to date with their training. SOPs were issued and reviewed by the head office team. Members of the team were sent an email when new SOPs were launched to ensure they completed the required training. Delivery drivers were also assigned procedures to read on their learning portal. Locum pharmacists were required to sign up to the system and complete SOP training before they were offered shifts.

Dispensing mistakes which were identified before a medicine was supplied to people (near misses) were highlighted to the team member involved in the dispensing process and recorded in a near miss log. The pharmacy manager reviewed the records at the end of each month to identify any trends or patterns. Findings from the review were discussed with the team. As a result of past reviews, some medicines had been separated in the drawers to avoid picking errors and the RP had a discussion with a team member who was repeatedly making mistakes. As part of the discussion, it was found that the team member was not double checking their own work before the final accuracy check. Medicines which looked-alike and sounded-alike were also highlighted. At the end of each review the RP recorded three points of what had been learnt on a post-it notes which was shared with the team and reviewed the following month.

Any instances where a dispensing mistake had happened, and the medicine had been supplied (dispensing errors) was investigated and reported on the electronic system. A copy of this was sent to the superintendent pharmacist (SI). The SI's team would contact the pharmacy if they felt any further action needed to be taken. Following an incident, team members were asked to make sure they completed a thorough accuracy check if a pharmacist had been involved in the dispensing process and not assume that it would be correct.

A correct Responsible Pharmacist (RP) notice was displayed. When questioned, team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. A complaints procedure was in place and team members tried to resolve complaints in the pharmacy where possible. The pharmacy had a poster which told people how they could provide feedback.

Emergency supply records, RP records and controlled drug (CD) registers were well maintained. Private prescription records were generally well maintained but the correct prescriber details were not recorded on all the records seen. Recently the pharmacy had stopped making records for unlicensed

medicines supplied. The RP provided an assurance that she would restart. Running balances for CDs were recorded and regularly checked against physical stock held in the pharmacy. A random balance was checked and found to be correct. CDs that people had returned to the pharmacy were recorded in a register and appropriately destroyed.

Assembled prescriptions, which were ready to collect, were stored in the dispensary and not visible to people using the pharmacy. The pharmacy had an information governance policy available, and its team members had completed training about it. Refresher training was completed on an annual basis. The pharmacy stored confidential information securely and separated confidential waste which was then shredded. Pharmacists had access to national care records and obtained verbal consent from people before accessing it. Consent was gained from people who had their medicines supplied in compliance packs when they signed up for the service.

The team were in the process of completing the refresher safeguarding training and had until the end of May 2024 to complete this. The RP had completed level three training and team members had all completed an eLearning module. When questioned, team members were able to explain the signs to look out for which may indicate a safeguarding concern. They also gave examples of two instances where they had sought additional help after being concerned about two individuals.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the pharmacy's workload effectively and they receive appropriate training to carry out their roles safely. Team members get regular feedback, and they are supported to keep their knowledge and skills up to date. Team members can provide feedback and concerns relating to the pharmacy's services.

Inspector's evidence

The pharmacy team comprised of the RP, who was the pharmacy manager, four qualified dispensers and a university student. A student also worked on Saturdays and the pharmacy were in the process of recruiting another dispenser. The student who worked on Saturday had only recently joined and was due to be enrolled on the medicines counter assistant training program. The pharmacy also had a delivery driver. The RP explained that she felt there would be a sufficient number of staff once a new team member was recruited. The team were observed working effectively together and were up to date with the workload.

The pharmacy had an arrangement with a nearby School of Pharmacy as part of which pharmacy students completed a three-week placement at the pharmacy. When they first started, students were provided with a health and safety briefing and had to read through SOPs. They were provided with a workbook by the university which also covered confidentiality.

Team members had annual appraisals with six monthly reviews and were also provided with ongoing feedback by the pharmacist. The team had regular catchups to see how they could improve and recently they had discussed the best way to complete tasks as the dispensing pattern had changed. As part of this discussion, they made sure that everyone was doing different tasks, so work was not building up, they had also discussed changing roles and tasks to help make sure the same person was not always doing the same jobs. The team kept the dispensary well run and made sure things were tidied up. Team members were able to raise concerns and give feedback. There was an opportunity for team members to progress in their roles and the pharmacy manager would need to speak to the regional team to make them aware.

Team members asked appropriate questions and counselled people before recommending over-the-counter medicines. They were aware of the maximum quantities of medicines that could be sold over the counter. Team members completed training modules online on their personal eLearning portal to keep up to date. Team members completed training at home on most occasions. However, if there was time at work or if the full team was working together then training was completed at work. Recent training had covered the new SOP bundle and team members had completed the training on the blood pressure service so that they could also provide this service. The pharmacy manager also briefed the team on new services that were to be provided or being launched.

As the team was small and worked closely together, any new information, issues or concerns were discussed as they arose. If there was a member of staff missing, the RP would brief them when they were next in. The RP attended a monthly conference call with the area manager and other branches. She cascaded relevant operational information related to the pharmacy from the call to the team. The company had an electronic application where colleagues could post any comments or feedback or

discuss ways of working. Head office set targets for the services provided by the pharmacist, although there was some pressure to meet these the RP confirmed that they did not allow the targets to compromise their professional judgement and it was about time management and learning how to change the mindset to achieve targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide a safe environment to deliver its services. People using the pharmacy can have a conversation with its team members in a private area.

Inspector's evidence

The pharmacy was clean, tidy, and organised. The dispensary was small but was clear of clutter and workspace was allocated for specific tasks. A clean sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by members of the team. The room temperature and lighting were appropriate. Team members described that it was warm in the summer months, and they kept both doors open to allow airflow and were also provided with portable air conditioning units. The premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for private conversations.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of service which are accessible. It provides its services safely and manages them well. The pharmacy gets its medicines from licensed suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use

Inspector's evidence

The pharmacy was easily accessible from the street with flat access. The shop floor was clear of any trip hazards and the retail area was easily accessible. Team members assisted people who needed help entering the pharmacy and the pharmacy provided a medicine delivery service. A hearing loop was available. The team were aware of services that were offered locally and also used the internet to find out the details of local services so that they could signpost people who needed services that the pharmacy did not provide. There was a good network with local GP surgeries. The RP described that one of the pharmacists based at the local GP practice had created a group on electronic messaging application with all local pharmacies. The group was used to check stock level, highlight any serious shortage protocols (SSP) and share communication.

The RP felt that the Pharmacy First and flu vaccination service had a positive impact on the local population. She described that people often found it difficult to book appointments and needed to access and complete an online form to make an appointment. There was a large elderly population locally who didn’t have access to technology, and it was easier for them to walk-in to the pharmacy. The RP gave an example of treating someone on Pharmacy First for shingles, the person had been into see their GP earlier in the week and had been prescribed pain relief, they had presented to the pharmacy after having developed a rash and was supplied with antiviral medicines by the pharmacist. The RP explained that the Pharmacy First service allowed pharmacists to treat common conditions like uncomplicated UTIs and ear infections. Where people did not meet the eligibility criteria there was a process for them to be referred.

Prescriptions were mainly received by the pharmacy electronically. These were either sent to the off-site Rowlands dispensing hub or dispensed in store. The off-site dispensing hub was used by pharmacy branches within the same company to assemble prescriptions. The hub then delivered the prescriptions back to the pharmacy so they could be supplied to people. All prescriptions were clinically checked by the pharmacist before either being sent to the hub or passed on to the dispensing team to assemble. 'Dispensed by' and 'checked by' boxes were routinely signed on dispensing labels, to create an audit trail showing who had carried out each of these tasks. Baskets were used to separate prescriptions, preventing the transfer of medicines between different people. Locum pharmacists were trained on how to use the system before they were allocated shifts.

Some people's medicines were supplied in a sealed medicine pouch to help them take their medicines at the right time. Prescriptions were labelled on site and were prepared at the hub. The RP clinically and accuracy checked the prescriptions and data before it was transmitted to the hub. The local hospital called when someone was admitted. Discharge information was usually sent to the surgery and the clinical pharmacist at the surgery would update the information. On some occasions team members asked family members to bring in a copy of the discharge summary. Assembled pouches seen in store

were labelled with product descriptions and mandatory warnings. The team were unsure about how patient information leaflets were supplied to people as these were not received with the assembled packs. The RP provided an assurance that she would find out.

Team members performed a quick visual check when they reconciled prescription forms with the bags. They explained that the error margin was very low. In the event that any errors were picked up they would be reported to the hub.

Team members were aware of the guidance for supplying sodium valproate and that the original pack could not be split and made sure warnings were not covered when attaching the dispensing label. All team members had been briefed on the guidance for dispensing sodium valproate by the RP. The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP) and any new prescriptions for sodium valproate were highlight so that the RP could have a consultation with them. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring, people were also provided with additional counselling. On some occasions a record was made on people's electronic record when checks were completed.

Deliveries were carried out by the delivery driver. The driver annotated the record with the time and date of delivery when medicines were delivered. In the event that someone was not home, medicines were returned to the pharmacy.

Prior to the launch of the Pharmacy First service the RP completed online training and watched videos on how to use equipment like the otoscope. She also went to the local surgery and asked the nurses to train her. Signed PGDs were available.

Medicines were obtained from licensed wholesalers and were stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of cold chain medicines. Team members were able to describe the actions they would take if the temperature was outside of the required range. CDs were kept securely. Expiry dates were checked routinely, the dispensary had been split into sections which were assigned by head office to team members and sections were checked in accordance with this. An updated date checking matrix was seen. Short dated medicines were highlighted with stickers. No date expired medicines were found on the shelves. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. Drug recalls were received from head office on the intranet. They were printed, shared with the team, actioned and the signed and filed away.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Equipment is kept clean and is ready to use.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment was also available. Equipment was clean and ready for use. A medical fridge was available. A blood pressure monitor, thermometer, otoscope, pulse oximeter and ambulatory blood pressure monitor were available and used for some of the services provided. Equipment was calibrated annually. Up-to-date reference sources were available.

The pharmacy's computers were password protected and screens faced away from people using the pharmacy. A cordless telephone was also available to ensure conversations could not be overheard.

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.