General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 36-40 Horsemarket, KELSO, Roxburghshire, TD5 7HD

Pharmacy reference: 1100664

Type of pharmacy: Community

Date of inspection: 30/09/2024

Pharmacy context

This is a community pharmacy in the town of Kelso in the Scottish Borders. Its main activity is dispensing NHS prescriptions and providing people with their medicines as individual doses in pouches, to help them take their medicines correctly. It provides a range of services including NHS Pharmacy First. And it provides a delivery service taking medicines to people in their 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
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 written procedures help team members manage risk to deliver services safely and effectively. Team members record mistakes made during the dispensing process and they make changes to help prevent the same or a similar mistake occurring. They mostly keep the necessary records required by law. And they keep people's private information secure. Team members respond appropriately to concerns about the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy's standard operating procedures (SOPs) helped team members manage risks to provide the pharmacy's services safely and effectively. The SOPs covered dispensing processes, controlled drug (CD) management and responsible pharmacist (RP) requirements. A sample of SOPs showed they were reviewed every two years. The pharmacy manager monitored compliance with the completion of SOPs and records showed all team members had completed the SOPs relevant to the pharmacy's services. A recently employed delivery driver had completed SOPs about the delivery service. The pharmacy's SOPs highlighted who was responsible for certain activities, for example the RP only or all colleagues.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The pharmacist recorded the details about the mistake and discussed it with the team member responsible. The near miss record showed that corrective actions were not always captured on the record which meant team members were not able to show what action they had taken to resolve the near miss. The pharmacy completed a monthly review of the data produced from the near misses. Team members had separated tramadol and trazodone in the pharmacy from each other in response to near misses. And they had highlighted that all CDs were to be double checked by a second team member. The pharmacy completed reports for mistakes that were identified after a person had received their medicines, known as dispensing incidents. The reports were recorded electronically and were shared with the company's superintendent (SI) pharmacist team. A dispensing incident showed that an error had been made where tramadol and trazodone had been mixed up when dispensing. This had taken place after the measures had been put in place as a result of the near misses, so actions put in place had not been as effective as they could have been. The pharmacy manager reiterated the learnings from the patient safety review to team members to help ensure further repeated errors involving these medicines were prevented. The pharmacy had a complaints procedure detailed in the pharmacy leaflet. Team members aimed to resolve any complaints or concerns informally. For any complaints they could not resolve, the details were escalated to the area manager or company's head office if necessary.

The pharmacy had current professional indemnity insurance. Team members knew which tasks could and could not take place in the absence of the RP. The RP notice was prominently displayed with the correct details of the RP on duty. The RP record was mostly completed correctly with the time the pharmacist ceased being the RP occasionally missing. The pharmacy recorded the receipt and supply of its CDs. The entries checked were generally in order, with minor omissions of the supplying wholesaler for received CDs. Team members checked the physical stock levels of medicines matched those in the CD register regularly, with recent entries showing this had been completed weekly. Records of CD medicines returned by people who no longer needed them were captured on receipt. And their destruction was witnessed by a registrant. The pharmacy kept certificates of conformity for unlicensed

medicines known as “specials” and full details of who the medicine was supplied to were kept which provided an audit trail. The pharmacy had complete records of supplies of medicines made against private prescriptions and retained the corresponding prescriptions.

The pharmacy displayed both NHS and company privacy notices in the retail area which informed people of how their data was used. Team members received annual training about information governance and General Data Protection Regulation. And records showed this was up to date. Team members separated confidential waste for either shredding on site or for uplift by a third party for destruction. This was due to certain waste being unsuitable for the shredder. Team members were aware of their responsibility to help safeguard vulnerable adults and children. And they had a safeguarding SOP to refer to if necessary. Team members, including the delivery driver, knew to refer any concerns to the pharmacist who would refer to the relevant people as necessary. The pharmacist was registered with the protecting vulnerable groups scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably qualified and team members in training to deliver its services safely. Team members complete ongoing training to help develop their skills and knowledge. They ask appropriate questions and give appropriate advice when assisting people with their healthcare needs.

Inspector's evidence

The RP at the time of the inspection was a locum who worked regularly in the pharmacy. The pharmacy employed a part-time resident pharmacist who worked three days a week. Locums worked in the pharmacy on the other days and on two days alongside the resident pharmacist. The RP was supported by five dispensers, one of whom was the pharmacy manager, and two of whom were trainee dispensers. In addition, the pharmacy had two dispensers and a trainee dispenser who were not present during the inspection. The pharmacy had employed a new delivery driver who had been given some training in the role by the pharmacy's previous delivery driver. Team members in training were enrolled on accredited training for their roles and the pharmacy manager was aware of the requirement to enrol the driver on accredited training within three months. The resident pharmacist acted as tutor for the trainees. And they had regular check ins with the trainees as to their progress or if they had any queries. All team members received protected learning time weekly with the most recent learning being a refresher on cold and influenza. The pharmacist had completed training to provide advice and medication for conditions under the NHS Pharmacy First service and had read the relevant patient group directions (PGDs).

There was an open and honest culture amongst the team, and they were observed supporting each other to complete the workload. Team members felt comfortable to raise professional concerns and had access to the area manager if necessary. The area manager visited the pharmacy regularly. And the pharmacy displayed details in its staffing area of a confidential telephone number they could contact to report concerns. Team members mostly worked full time and worked the same days each week. Team members were informed of the tasks they were responsible for each day. Annual leave was planned in advance and the pharmacy generally only allowed one team member to be absent at a time. If necessary, part-time team members could increase their hours or the pharmacy could ask for support from other pharmacies in the company to support periods of absence. The pharmacy's performance review process had not yet been fully implemented for all its team members as the pharmacy had changed ownership less than a year previously. Two newly employed team members had received reviews as part of their induction process. Team members received daily communications from the company's head office with information about pharmacy operations.

Team members knew the appropriate questions to ask when selling medicines over the counter. They were vigilant to repeated requests for medicines liable to misuse, for example medicines selling codeine. They referred such requests to the pharmacist who would have supportive conversations with people and refer them to their GP.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are spacious, secure and suitable for the services the pharmacy provides. It has appropriate facilities where people can have private conversations with team members.

Inspector's evidence

The pharmacy had a spacious retail area and dispensary which portrayed a professional appearance. A barrier at the medicines counter helped prevent unauthorised access to the dispensary. The dispensary was positioned in a way that provided privacy for dispensing activities to take place. It had different benches allocated for the completion of different tasks including dispensing and preparation of medicines in multi-compartment compliance packs. The pharmacist's checking bench was positioned to allow effective supervision of the dispensary and medicines counter. There was a rear storage area which included space for team members to have their breaks. The pharmacy was cleaned thoroughly weekly according to a rota. Countertops were cleaned on a daily basis. The dispensary and staffing area had a sink which provided hot and cold water for handwashing. Toilet facilities were clean and provided separate hot and cold water for handwashing.

The pharmacy had a private room which allowed people to have private conversations with team members and access services. It had a desk, chairs and a computer for consultations to be completed comfortably. It had a sink which provided hot and cold water. Lighting provided good visibility throughout and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services well. And it makes them accessible to people. Team members provide people with the necessary information to take their medicines safely. They obtain medicines from recognised suppliers, and they complete regular checks on them to ensure they remain fit for supply. They respond appropriately to alerts about the safety of medicines.

Inspector's evidence

The pharmacy displayed its opening hours at the front entrance. It was accessed from the street via a small step into the retail area. There was a ramp which could be used to allow ease of access to those using wheelchairs or with prams. The pharmacy had an automatic door, but this was not working. Team members had reported it and were waiting for it to be repaired. They assisted people with hearing difficulties by taking them to the consultation room where it was quieter. And they used translation applications for those whose first language was not English. They signposted people to other nearby pharmacies for services they did not offer.

Team members used baskets to keep people's prescriptions and medicines together and prevent them becoming mixed-up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members used stickers to highlight the inclusion of a fridge line or controlled drug or if the pharmacist wanted to speak to a person when their medicine was handed out. The CD stickers allowed the pharmacist to record the expiry date of the CD prescription so team members could check if it was l egally valid before it was handed to a person. Most team members were aware of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate. They knew not to cover the additional information provided on the manufacturer's pack and were aware of legislation for providing valproate in manufacturer's original packs. Team members provided people with an owing slip which was a record of the medicines that were out of stock. They checked prescriptions with owed medication daily and if they unable to be supplied, they contacted the person's GP for an alternative. Team members were observed completing suitable checks when handing out medicines to people to ensure they were given to the correct person.

The pharmacy had recently introduced a new way of dispensing some people's medicines to help them take their medicines correctly. People received a week of their medication at a time, dispensed into individual pouches on a roll. Each pouch contained all a person's medicines for a specific time and date, so people didn't have to remember to take their medicines out of different medicine packages. The pharmacy manager and a dispenser had spoken to and assessed each individual's suitability to have their medicines dispensed in the new way. There were some people who were assessed as being more suitable to remain taking their medicines from multi-compartment compliance packs. The pharmacy received prescriptions from the surgery ahead of them being required so that any queries could be resolved. Each person had a medication record which detailed the medication and administration times. The pharmacist completed a clinical and data accuracy check before the information was transferred to a central hub pharmacy in the company for the pouches to be dispensed, using automation. The pouches were supplied back to the pharmacy weekly from the central hub pharmacy. They contained descriptions of the medicines in the pouches and patient information leaflets (PILs) were supplied to people monthly. Any changes to a person's medication were communicated from the

person's GP and the person's medication record updated. For urgent changes, team members could telephone the central hub and have a new set of pouches issued within 24 hours. The pharmacy supplied medicines to people in care homes. The care home staff ordered the prescriptions and checked that all ordered medicines were present. The pharmacy dispensed the medicines in the original manufacturer's pack or into multi-compartment compliance packs. And they provided the care homes with medication administration charts so the administration of medicines could be recorded.

The pharmacy provided a delivery service, taking medicines to people in their homes. The driver used a paper record of the deliveries to be made. This was signed by the person receiving the medicine where they were able, to confirm receipt. Medicines that could not be delivered were returned to the pharmacy with a card left through the person's letterbox informing them of the attempted delivery. Team members used a centralised hub pharmacy to dispense some of its prescriptions. The pharmacist completed a clinical and data accuracy check before transferring the details of the prescriptions electronically to the hub pharmacy. The hub pharmacy delivered the completed medicines back to the pharmacy within 48 hours and team members matched the medicines to the prescriptions on receipt.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were stored in clear plastic boxes in the retail area informing people to ask for assistance if they required the medicines. Team members had a process for checking the expiry dates of medicines and records showed this was up to date. Medicines that were going out of date in the next few months were highlighted for use first. And medicines with a shortened expiry date on opening were marked with the date of opening. A random selection of ten medicines found a liquid medicine which had passed its expiry date after opening and this was removed during the inspection. The pharmacy had two fridges and team members recorded the temperatures daily. Records showed that the fridges were operating between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls via the company's daily communication. They were printed, actioned and retained in a folder as proof of action taken. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has suitable equipment to provide its services. Team members generally use the equipment in a way that protects people's private information

Inspector's evidence

The pharmacy had access to electronic reference resources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had an automated dispensing machine used to dispense doses of medicine used in the substance misuse service, which was cleaned and calibrated daily. Measuring cylinders were ISO or crown-stamped and were marked to show which were used for liquid medicines and for water. The pharmacy had triangles used to count tablets. It had a blood pressure machine which had been in use less than a year.

The pharmacy's cordless telephone to help ensure conversations could be kept private didn't work. The company were aware of the issue and team members were waiting on a resolution. There was a corded telephone which team members were using which was far enough away from the retail area, so conversations were kept as private as possible. The pharmacy stored medicines awaiting collection away from public view to protect people's private information. Confidential information was secured on computers using passwords and screens were positioned in the dispensary preventing unauthorised access to confidential information.

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.