General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 6 High Street, Ferrybridge, KNOTTINGLEY, West Yorkshire, WF11 8NQ

Pharmacy reference: 1115265

Type of pharmacy: Community

Date of inspection: 03/12/2019

Pharmacy context

This community pharmacy is amongst a small parade of shops in the village of Ferrybridge. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the flu vaccination service. And it provides the supervised methadone consumption service.

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 identifies and manages the risks associated with its services. And it has up-to-date written procedures that the team follows. The pharmacy has suitable arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The pharmacy keeps the records it needs to by law. The team members have training and guidance to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members record errors they make when dispensing. And they act appropriately to prevent future mistakes. Sometimes they don't record enough detail of why the error happens and they don't regularly review the error records. So, the team does not have all the information it could to help identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read the SOPs and signed the SOP signature sheets to show they understood and would follow them. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The pharmacy did not regularly review these records to spot patterns and make changes to processes. The last review was done in April 2019. This review reminded the team to always dispense from the prescription and not the label. The team members put notes on to the shelves holding products they noticed were often involved with errors. For example, a note attached to the shelves holding citalopram prompted the team to check the strength selected. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. All the team were informed of the dispensing incident. So, they could reflect and learn from it. The incident report gave drop down options for sections such as causative factors or the team could add information by free-typing. A sample of completed dispensing incident reports looked at found that information such as causative factors and actions taken were not always recorded.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare

products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it safeguarded people's private information. The team used the pharmacy's NHS email address when communicating with the GP teams. As this provided better security when sharing confidential information. The team separated confidential waste for shredding onsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacists and pharmacy technician had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team had not had the occasion to raise a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. It gives team members regular feedback on their performance. So, they can take opportunities to develop and keep their skills up to date. The team members have opportunities to complete regular training relevant to their roles. And so, keep their knowledge up to date. The team members support each other in their day-to-day work.

Inspector's evidence

A full-time pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of a full-time pharmacy technician who was also an accuracy checking technician (ACT) and the pharmacy manager, four part-time qualified dispensers, a part-time trainee dispenser, a part-time medicines counter assistant and a part-time delivery driver. At the time of the inspection a locum pharmacist, the ACT, two qualified dispensers and the trainee dispenser were on duty. The qualified team members supported the trainee dispenser. The ACT and regular pharmacist had worked together to get ahead with tasks such as recording the outcomes from the NHS services the pharmacy had provided. So, now these tasks took less time to complete and they did not impact on other work.

The pharmacy provided extra training through e-learning modules. The team members had some protected time to complete the training. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The pharmacy team had access to a company confidential helpline to raise concerns. The pharmacy had targets for services such as Medicine Use Reviews (MURs). And the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. And it manages its services well. The pharmacy keeps records of deliveries it makes to people's homes. So, it can deal with any queries effectively. The pharmacy gets is medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via a step free entrance. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. And the team wore name badges detailing their role. The team had access to the internet to direct people to other healthcare services. A range of easy to read healthcare information leaflets were available. Topics covered by these leaflets included dry skin and sore throats. The pharmacist manager came in on their day off to collect some dressings to take to a person. The pharmacy had up-to-date patient group directions (PGDs). These provided the pharmacists with the legal authority to administer the flu vaccination. But the regular pharmacist had not signed the PGDs. The flu vaccination service was popular. People liked the convenience of the service and the gentle technique used by the pharmacist when administering the vaccine.

The pharmacy provided multi-compartment compliance packs to help around 70 people take their medicines. And people living in three care homes. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Many prescriptions were in the repeat dispensing format which the GP team had set up to allow the prescription to be released one week before supply. The person receiving the packs ordered any medicines not included in the pack such as inhalers themselves. Or they contacted the pharmacy to ask the team to request the medicine. The team found that asking people to ring the pharmacy when ordering these medicines provided an opportunity for the team to check the person was taking these medicines. For example, a person prescribed two types of inhaler but only requesting one would trigger the team to find out why. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The pharmacy team sent the repeat prescription forms to the care home teams who ordered the prescriptions two weeks before supply. But not all the care home teams sent the pharmacy team details of the medicines ordered. So, the pharmacy team did not know what medicines were missing when the prescriptions arrived at the pharmacy. The pharmacy team sent the packs one week before the next cycle. This allowed time for the care home team to check the supply and chase up missing medicines.

The team used a room to the rear of the main dispensary to dispense and check the multi-compartment compliance packs. This was away from the distractions of the retail area. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer’s patient information leaflets. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary against the medication list for changes or new items. The team shared the information with the GP team with a request for prescriptions when required. The team updated the medication list with any changes. And included who had asked for the change and the date the change

was requested. The team members used the information they captured about medicine changes when querying prescriptions. For example, the team had received notification of an increase in strength for a medicine. But the prescription sent was for the lower strength. The team checked this with the GP who advised the lower strength was to add to the previous supply to make the dose up to the higher strength. But this had not been clearly written on the prescription.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses with the prescription in the controlled drugs cabinet in tubs labelled with the person's name and address. This helped to reduce the risk of selecting the wrong one.

The pharmacy used the Rowlands offsite dispensary for most prescriptions. The process usually took three days. The team processed the prescription before sending the details to the offsite dispensary for dispensing. And the offsite dispensary returned the medicines on the third day. The team placed prescription awaiting processing in baskets labelled with the week day and in alphabetical order. So, the prescription could be found if the person needed it urgently. The team inputted data from the prescriptions on to the person's electronic medication record. And placed the prescriptions in baskets awaiting a clinical check and an accuracy check before sending the details to the offsite dispensary. The ACT or pharmacist undertook the accuracy check of the prescription. The pharmacist performed a clinical check and recorded their GPhC registration number. The offsite dispensary would not dispense prescriptions for controlled drugs, fridge lines and split packs. The team marked prescriptions that had medicines dispensed at the pharmacy rather than the offsite dispensary. So, the team knew what medicines they had to dispense. The team placed prescriptions to be dispensed at the offsite dispensary in labelled baskets. The team could ask for the return of the prescription if a person needed their medicines before it was due back from the offsite dispensary. The offsite dispensary returned the completed prescriptions in bags labelled with a bar code. The team scanned the bar codes before placing them on shelves awaiting collection or delivery. And the team added any medicines not dispensed at the offsite dispensary. The team reported to the company issues with the offsite dispensary sometimes returning prescriptions with missing medicines.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. And they used this as a prompt to check what they had picked. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack to provide people with information when required. The pharmacy team members highlighted prescriptions for high-risk medicines such as warfarin to prompt them to ask the person for information such as latest blood tests and the dose they were taking. The team recorded this information on to the person's electronic record (PMR). The pharmacy had a computer on the pharmacy counter so the team could check what stage a person's prescription was at when they presented at the pharmacy. And the team member would not have to disturb other team members using the dispensary computers.

The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacist marked the prescription to show they had

completed a clinical check so the ACT could do the accuracy check. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was in October 2019. The team marked medicines with a short expiry date. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had equipment to meet the requirements of the Falsified Medicines Directive (FMD). And the team were using it. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had two fridges to store medicines kept at these temperatures. The team used one fridge for stock and the other fridge for prescriptions awaiting collection. So, the team could easily find stock and prescriptions when people came to collect their medicines. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.