General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, Unit 2, Greenlaw Village, Newton Mearns, GLASGOW, G77 6GR

Pharmacy reference: 1117252

Type of pharmacy: Community

Date of inspection: 01/06/2023

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via patient group directions (PGDs).

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

Pharmacy team members follow safe working practices. And they manage dispensing risks to keep services safe. Team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law. Team members make records of mistakes and review the pharmacy's processes and procedures. They learn from these mistakes and take the opportunity to improve the safety of services.

Inspector's evidence

The company used standard operating procedures (SOPs) to define the pharmacy's working practices. And it issued the SOPs via its online operating system for team members to refer to. The responsible pharmacist (RP) received notification emails and instructed team members to read and annotate the SOPs to confirm they followed them. They also signed and returned a declaration to the superintendent's (SI) office to confirm the pharmacy team had read them. Records showed the SI's office had recently reviewed and re-issued the RP SOP. And information showed it was next due a review in April 2025. Dispensers signed medicine labels to show who had dispensed and who had checked prescriptions. This meant the pharmacist was able to help individuals learn from their dispensing mistakes. The RP recorded the near miss errors, and they carried out monthly reviews and discussed the errors and any trends to help team members identify dispensing risks and make improvements. They also used the records to support trainees to identify learning gaps and provide them with extra support when necessary. Team members provided evidence of improvements, for example they had separated olanzapine, quetiapine, and venlafaxine due to selection errors. A team member from the SI's office carried out a professional standards audit at least annually. And the pharmacy demonstrated compliance with professional standards at the last audit. A regional manager visited the pharmacy on a regular basis. And this was an opportunity to discuss the pharmacy operations, such as resources.

The pharmacy trained its team members to handle complaints. And a notice at the medicines counter provided information about the complaints process and provided contact information.
Team members knew to report dispensing mistakes that people reported after they left the pharmacy. And the pharmacist produced a report using an electronic template which they sent to the SI's office. The template included a section to record information about the root cause and any mitigations they introduced to improve safety arrangements.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place which were valid until 29 June 2023. The pharmacist displayed an RP notice which was visible from the waiting area. And the RP record showed the name and registration details of the pharmacist in charge. Team members maintained the controlled drug (CD) registers and kept them up to date. And they evidenced that they carried out balance checks once a week. People returned CDs they no longer needed for safe disposal. And team members used a CD destruction register to document items which the pharmacist signed to confirm destructions had taken place. Team members filed prescriptions so they could easily retrieve them if needed. And they kept records of supplies against private prescriptions and supplies of specials that were up to date. The pharmacy provided regular mandatory training so that team members understood data protection

requirements and how to protect people's privacy. And they used a shredder to dispose of confidential waste. A notice at the medicines counter provided information about the pharmacy's compliance with data protection legislation. And the pharmacy provided regular mandatory training so that team members effectively managed safeguarding concerns. Team members provided examples of when they had spoken to the pharmacist when they had cause for concern. The pharmacy had contact details for local agencies for ease of access.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And they work together well to manage the workload. Team members continue to learn to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's prescription workload had increased over the previous year. And the company had authorised the pharmacy to recruit an extra part-time trainee dispenser to help manage the increased workload. The pharmacy was in the process of recruiting a full-time accuracy checking technician (ACT) and a full-time dispenser to replace team members that had left. A relief dispenser and a pharmacy student were providing cover at the time of the inspection. And the three pharmacy students that usually worked Saturdays also worked weekdays to provide extra cover when required. Two long-serving job-share pharmacists worked at the pharmacy. And most of the other team members were long-serving and experienced in their roles and responsibilities. The company arranged locum pharmacist cover in advance. And it also provided authorisation so they had access to the relevant pharmacy systems in advance. The following team members worked at the pharmacy; two part-time pharmacists, three part-time dispensers, one part-time trainee dispenser, three pharmacy students and one part-time driver.

A newly recruited pharmacy team member was in the process of completing mandatory training as part of their induction period. This included completing training modules covering information governance, the UK General Data Protection Regulation (GDPR), and safeguarding vulnerable adults and children. It also included reading the pharmacy's policies and procedures that were relevant to their roles and responsibilities. The company enrolled new staff on qualification training once they had completed induction training. And the pharmacy provided protected learning time in the workplace for them to complete it. All team members completed regular mandatory training. This included keeping up to date with changes to SOPs and reading the UK GDPR and safeguarding procedures.

The pharmacy supported team members to learn and develop and keep up to date with changes and new initiatives. For example, they had discussed the pharmacy's flu and travel vaccination services. This helped them to describe the service to people that wished to use it. Team members also completed training so they could provide the smoking cessation service and carry out blood pressure monitoring activities. The RP had recently supported a dispenser to handle a query about an antibiotic prescription for an infant. And they had contacted the SI's office for further information. The pharmacist was in the process of registering to undertake pharmacist independent prescriber (PIP) training. And they kept up to date with vaccination competency requirements.

The RP empowered team members to suggest new ways of working to improve the pharmacy's safety and effectiveness. And team members provided examples of when they had implemented improvements. This included labelling the pharmacy's shelves to help new team members identify and correctly select items for dispensing. This included commonly used items and other items such as antibiotics. This had helped them to learn and to manage selection errors. Team members at the medicines counter managed stock levels to meet demands. And they kept up to date with NHS

Pharmacy First formulary changes. Team members had completed training so they understood their obligations to raise whistleblowing concerns if necessary. And they knew to refer concerns to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises support the safe delivery of its services. And it effectively manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

The company had refurbished the pharmacy in October 2022. And it provided a modern, purpose-built environment from which to safely provide services. A sound-proofed consultation room with a sink was available for use. And it provided a clinical environment for the administration of vaccinations and other services such as blood pressure monitoring. The consultation room provided a confidential environment. And people could speak freely with the pharmacist and the other team members during private consultations. A small separate private counter to the side of the medicines counter was available for those that wished to use it. And team members regularly cleaned and sanitised the consultation room and the pharmacy. This ensured they remained hygienic for its services. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate room provided adequate space for team members to take comfort breaks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

A step-free entrance provided access to the pharmacy, and this helped people with mobility difficulties. The pharmacy provided a seasonal flu vaccination service. And following a risk assessment it had ceased to provide its travel vaccination service due to its vacant posts. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were safe to supply. They checked expiry dates once a week and kept audit trails to evidence when checks were next due. This managed the risk of supplying short-dated stock in error. The pharmacy used two fridges to keep medicines at the manufacturers' recommended temperature. And team members monitored and recorded the temperature to provide assurance it was operating within the accepted range of two and eight degrees Celsius. The pharmacy used one of the fridges for dispensed items awaiting collection. And these were kept in clear bags so they could be easily identified. Team members kept stock neat and tidy on a series of shelves. And they used secure CD cabinets for some of its items. Medicines were well-organised and items awaiting destruction were kept well-segregated from other stock.

Team members produced an audit trail of drug alerts. And they evidenced they had checked for affected stock so it could be removed and quarantined straight away. This included a recent drug alert for Emerade injections. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so as not to cover-up the warning messages. The pharmacy mostly supplied original packs which contained patient information leaflets and information cards. And they had spare information leaflets in the event they needed to supply split packs.

The pharmacy used dispensing baskets for the different types of prescriptions it received. For example, it used separate baskets for prescriptions for multi-compartment compliance packs and prescriptions team members sent to an offsite hub dispensary. This helped them to effectively manage dispensing and effectively retrieve prescriptions in a safe and timely manner when required. Team members also used dispensing baskets to safely hold medicines and prescriptions during the dispensing process. And this helped to manage the risk of items becoming mixed-up. The pharmacy supervised the consumption of some medicines. And team members dispensed doses in advance, so they were available for people to collect. They obtained a clinical and accuracy check at the time of dispensing. And the pharmacist carried out a final accuracy check at the time they made the supply.

The pharmacy supplied medicines in multi-compartment compliance packs to help people with their

medication. And they used a separate rear area to assemble and store the packs. Trackers helped team members to plan the dispensing of the packs. And this ensured that people received their medications at the right time. They also used supplementary records that provided a list of each person's current medication and dose times which they kept up to date. And they checked new prescriptions against the records for accuracy. Team members provided descriptions of medicines. And they supplied patient information leaflets for people to refer to. Some people collected the packs either themselves or by a representative. And team members monitored the collections to confirm they had been collected on time. This helped them to identify when they needed to contact the relevant authorities to raise concerns.

The pharmacy dispensed serial prescriptions for people that had registered with the Medicines: Care and Review service (MCR). The pharmacy had a system for managing dispensing. And they retrieved prescriptions every Monday so they could order items and dispense by the following Wednesday. Most people collected their medication when it was due. And team members knew to refer people who arrived either too early or too late so the pharmacist could check compliance. The pharmacy checked its retrieval area every four weeks. And they removed items and placed them in a container whilst they contacted people via text to remind them to collect their medication. This helped the team members to check compliance and contact the relevant services if they had any concerns.

An off-site dispensary assembled and dispensed a significant number of prescriptions on behalf of the pharmacy. The team members followed the company’s SOPs to ensure the prescriptions were safely processed and transmitted to the hub dispensary using the pharmacy medication record (PMR). This included a requirement for team members to enter the prescription information accurately. It also included the requirement for the RP to carry out the relevant clinical and accuracy checks before authorising and transmitting the prescription information to the hub. The RP annotated prescription forms using a stamp. And this showed they carried out the necessary clinical checks. The PMR system used a colour-coded facility to highlight the different types of prescriptions so that team members could effectively carry out checks. For example, prescriptions for the hub dispensary showed as a green label. The hub dispensary returned prescriptions within 48 hours. And it placed them in a tote that it sealed with black coloured tape so that team members could quickly identify them. Team members carried out accuracy checks before placing the prescriptions on the shelf for collection. This included counting items via a clear panel on the bag and checking for extra items that needed to be added.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for methadone. They had highlighted the measures, so they were used exclusively for this purpose. Team members used a blood pressure monitor. They had recently arranged a replacement, but they could not show the date of renewal. This meant they could not track when next to replace it.

The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could carry out conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes.

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.