General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, Wilsden Medical Centre, Lingbob Court, Wilsden, BRADFORD, West Yorkshire, BD15 0NJ

Pharmacy reference: 1121565

Type of pharmacy: Community

Date of inspection: 24/04/2023

Pharmacy context

The pharmacy is adjacent to a medical centre in Wilsden. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide services to people, including the NHS Hypertension Case Finding Service, seasonal flu vaccinations and the NHS New Medicine Service (NMS). And they provide medicines to some people in multi-compartment compliance packs.

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 adequately identifies and manages risks associated with its services. And it has documented procedures to help it provide services effectively. Pharmacy team members understand their role in helping to protect vulnerable people. And they suitably protect people's private information. They record and discuss the mistakes they make so that they can learn from them. But they don't always document why mistakes happen and so they may miss opportunities to make improvements to the pharmacy's services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. Pharmacy team members accessed these electronically. All team members were aware of how to access the procedures using the company's intranet system. The SOPs were reviewed by head office periodically. And pharmacy team members received the reviewed SOPs to read via the company's training platform, usually in bundles of several procedures. They used the platform to record they had read and understood each procedure. Team members had read the most recent bundle in the first quarter of 2023. The pharmacy had an accuracy-checking Pharmacy Technician (ACT) who was trained to perform a final accuracy check of prescriptions. The pharmacy had a documented procedure in place that defined the role of the ACT. And the ACT said that the boundaries of their role had been further defined locally by discussion with the pharmacist. They explained clearly how prescriptions were clinically checked by the pharmacist as they arrived in the pharmacy. And the pharmacist had a system for marking prescriptions to confirm they had performed a clinical check. The ACT confirmed that they would not check a prescription that had not been marked. And would refer any unmarked prescriptions back to the pharmacist before performing the final accuracy check.

The pharmacy was providing a busy NHS Blood Pressure Check (Hypertension Case Finding) Service. The pharmacist carried out face-to-face consultations with people to test their blood pressure. This helped to determine whether people had, or were at risk of developing, high blood pressure. The pharmacist then provided people with further help, including providing them with a machine to monitor their blood pressure at home over 24-hours or by referring them to their GP or hospital if necessary. The pharmacist who provided the service was not available during the inspection. Pharmacy team members explained how they had considered some of the risks of delivering the blood pressure check service to people, such as the suitability of the pharmacy's consultation room to deliver the service from, ensuring that team members had completed the necessary training, the availability of the necessary equipment, and having the correct SOPs in place. Team members did not know if these assessments had been written down to help them manage emerging risks on an ongoing basis. And they did not know where to find the relevant NHS service level agreements or training information for the people delivering the service.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made when dispensing. There were documented procedures to help them do this effectively. They discussed their errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. For example, they had separated look-alike and sound-alike (LASA) medicines on the shelves, to help prevent the wrong medicines being selected, for example different strengths of venlafaxine tablets. Pharmacy team members did not

always capture enough information about why the mistakes had been made or the changes to prevent a recurrence to help aid future learning. But they gave their assurance that these details were always discussed. The pharmacy manager analysed the data collected every month to look for patterns. They recorded their analysis. And pharmacy team members discussed the patterns found at a monthly patient safety briefing. They displayed the key points from each meeting on a notice board for everyone to refer to while they worked.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained people usually provided verbal feedback. Any complaints were immediately referred to the pharmacist to handle. The pharmacy had a poster available, which included information for people about how to provide the pharmacy with feedback. The pharmacy had up-to-date professional indemnity insurance in place. It kept accurate controlled drug (CD) registers, with running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity every week. The pharmacy kept and maintained an accurate register of CDs returned by people for destruction. It maintained a responsible pharmacist record, which was complete and up to date. The pharmacist displayed their responsible pharmacist notice. Pharmacy team members monitored and recorded fridge temperatures daily. They kept accurate private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It shredded confidential waste. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information. Pharmacy team members had signed to confirm they had understood the procedure, and they explained how important it was to protect people's privacy and how they would protect confidentiality. They completed mandatory confidentiality and information security training every two years and had last completed training in 2023. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would refer their concerns to the pharmacist. The pharmacy had procedures for dealing with concerns about children and vulnerable adults. Pharmacy team members completed mandatory safeguarding training every two years. And they displayed local safeguarding contact information on a notice board for people to refer to.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete regular ongoing training suitable for their roles. The pharmacy generally listens when pharmacy team members raise concerns and make suggestions to help improve pharmacy services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist, a pharmacy technician, who was also trained to perform the final accuracy check of appropriate prescriptions, and a dispenser. Team members were coping well with the workload and the pharmacy was operating smoothly.

The pharmacist and pharmacy technicians were subject to revalidation as part of the professional registration. All pharmacy team members were also required to complete online e-learning modules sent by head office periodically on the company's online training system. Pharmacy team members explained they were up to date with their training modules, which they completed every few months. The modules covered various topics, including recent training on information governance and safeguarding. The pharmacy had a yearly appraisal process for team members. But team members explained they had not had an appraisal with a manager in several years. They expected this to change as they now had a new manager and anticipated having an appraisal in 2023. Team members explained they would raise any learning needs with the pharmacist informally, who would support them by teaching and by signposting them to appropriate resources to help their learning.

Pharmacy team members explained how they would raise professional concerns with the pharmacy manager, regional manager or with the company’s human resources team. They felt comfortable raising a concern. And were confident that their concerns would be considered, and changes would be made where they were needed if these were raised with the immediate pharmacy team. One recent example was the team introducing a colour-coded basket system to help them quickly identify and process prescriptions for people waiting in the pharmacy. Pharmacy team members were less confident about raising and discussing concerns with their regional manager. The pharmacy had a whistleblowing policy in place. And team members communicated with an open working dialogue during the inspection.

Pharmacy team members explained how the company set the team targets to achieve in various areas of the business. These included the number of prescriptions items dispensed, the number of service consultations provided to people, and the number of people nominated to use the pharmacy to have their electronic prescriptions dispensed. Team members discussed how they felt there was an increasing pressure from the company to provide a defined number of service consultations to people each day. And the impact this was having on the team’s morale. But they were confident they were still able to exercise their professional judgment and only provide services to people who needed them.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a private consultation room, which was clearly signposted, and pharmacy team members used the room to have private conversations with people. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a staff toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy kept its heating and lighting to acceptable levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely and effectively. The pharmacy sources and stores its medicines appropriately. And it generally manages its medicines effectively. The pharmacy's services are accessible to people, including people using wheelchairs. And it has processes in place to help people understand and manage the risks of taking higher-risk medicines.

Inspector's evidence

The pharmacy had level access from the street through automatic doors. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And they could provide large-print labels and instruction sheets to help people with a visual impairment.

The pharmacy had a good proportion of its prescriptions dispensed at the company's off-site dispensing hub, where medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions were assessed to establish whether they were suitable to be sent to the hub. They continued to dispense prescriptions for urgent acute items, such as antibiotics, medicines stored in the fridge and for prescriptions for unusual quantities of medicines. They used the hub most commonly for people's regular repeat medication. Pharmacy team members annotated on the electronic prescription token which items were being sent to the hub and which items were for the team to dispense. The pharmacist logged on to the system and performed a clinical and accuracy check of each prescription. Once the pharmacist was satisfied, they released the prescription which was then sent to the hub for assembly. The pharmacy received the medicines in sealed packages from the hub. Pharmacy team members married up the bags with the relevant prescriptions and any medicines that had already been prepared in the pharmacy. And the bags were added to the prescription retrieval shelves ready for collection or delivery.

The pharmacy also sent prescriptions to a hub for people who required their medicines in multi-compartment compliance packs. These prescriptions were clinically checked by the pharmacist against the pharmacy's master records every six months, or if a change was made to people's regular medicines. In the packs, medicines were provided in pouches that were marked and corresponded with the day and time they were due to be taken. Each pouch was labelled with details of the contents. And each pack had a sheet attached which gave descriptions of what each medicine looked like, so they could be identified in the pack. Pharmacy team members documented any changes to medicines provided in packs on the patient's master record sheet, which was a record of all their medicines and the times of administration. They also recorded this on their electronic patient medication record (PMR). They explained that people received information leaflets about their medicines when they were first prescribed. But leaflets were not routinely provided after that.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. The pharmacist clinically checked each prescription, ready for the pharmacy technician to perform the final accuracy check once the prescriptions had been dispensed. The technician gave clear examples of the types of prescriptions they were not permitted to check, such as prescriptions for controlled drugs and prescriptions for some high-risk medicines, such as methotrexate. Pharmacy team members used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up.

The pharmacist counselled people receiving prescriptions for valproate if they were at risk. They checked if the person was aware of the risks if they became pregnant while taking the medicine. And whether they were on a pregnancy prevention programme and using effective contraception. The pharmacy had stock of some information materials to give to people to help them manage the risks of taking valproate. The pharmacy team members present during the inspection explained that pharmacy had carried out an audit of people who received valproate from the pharmacy, to help to ensure that the right people had received the appropriate information and counselling. But they did not know the outcome of the audit or where the audit documents were kept so they could refer to them later.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridges each day and recorded their findings. The temperature records seen were within acceptable limits. Team members recorded weekly checks of medicine expiry dates. They completed checks in various areas of the pharmacy on a rolling cycle. This meant they checked all medicines every three months. Pharmacy team members highlighted and recorded any short-dated items up to three months before their expiry. The pharmacy did not have a process in place to remove expired items if they expired before the next scheduled check, other than people noticing highlighted packs while dispensing. After a search of the shelves, no out-of-date medicines were found. Pharmacy team members responded to any alerts or recalls they received about medicines from manufacturers and other agencies. They removed any affected medicines from the shelves, and they recorded the actions they had taken.

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 it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected.

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.