General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 72-74 Ballindean Road, DUNDEE, Angus, DD4 8NU

Pharmacy reference: 1041717

Type of pharmacy: Community

Date of inspection: 16/02/2022

Pharmacy context

This is a community pharmacy in a suburb of Dundee. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. This pharmacy was inspected during the COVID-19 pandemic.

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 mostly identifies and manages the risks with its services including reducing the infection risk during the pandemic. The pharmacy team members follow written processes for the pharmacy's services, which they review, to help ensure they provide them safely. The pharmacy keeps the records it needs to by law, and it keeps people's private information safe. Team members record only some of the mistakes they make and do not regularly review them. So, they may miss opportunities for learning and avoiding the same mistakes happening again.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter, had hand sanitiser for team members and people using the pharmacy, and limited access to four people at a time to enable social distancing. Most people coming to the pharmacy wore face coverings and team members all wore masks. They cleaned surfaces and touch points and washed and sanitised their hands regularly and frequently.

The pharmacy had standard operating procedures (SOPs) which team members followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members described their roles. And they accurately explained which activities could not be undertaken in the absence of the pharmacist and this was observed. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines. Over the past few months, the pharmacy had experienced challenges with team members' absence and resignations. So, some routine tasks including recording near misses had not been undertaken. But recently this had been re-introduced and most incidents were recorded. The team had not reviewed errors to learn from them for a long time. But team members hoped to do this at the end of this month and ongoing. A team member from another area had recently reviewed all processes in the pharmacy and made changes. This had included instalment dispensing and medicines supplied in multi-compartment compliance packs, medicines storage, and the management and assembly of MCR serial prescriptions. The pharmacy had a complaints procedure and welcomed feedback.

The pharmacy had indemnity insurance, expiring 31 March 2022. The pharmacy displayed the responsible pharmacist notice and kept a responsible pharmacist log. But sometimes pharmacists did not record all detail such as sign out times. And sometimes the pharmacist 'signed out' rather than recording 'absence'. This affected what activities team members could undertake when the pharmacist was on a rest break. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited, although not as often as the SOP required. And some dates in the CD registers were incomplete. It had a CD destruction register for patient returned medicines. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality and had completed training. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had read a SOP on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The delivery driver had completed training and described examples of taking appropriate action in a few situations.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough experienced team members to safely provide its services. The pharmacy does not always set aside time for them to continue their learning so they may find it difficult to keep their knowledge up to date. But team members from other branches are supporting and training the pharmacy's team members in reviewed and improved processes.

Inspector's evidence

A regular pharmacist had not been working in the pharmacy for several months. And the pharmacy was relying on a variety of locum pharmacists working so there was little continuity. On the day of inspection, a locum pharmacist was starting a run of five days which the team welcomed. The pharmacy had experienced a challenging few months, as most team members had left in October (four months ago). And two team members had been on long term leave. An experienced dispenser/manager from a Rowlands pharmacy in England had been working in the pharmacy over the past few weeks to support the team and improve the running of the pharmacy. She was effectively reviewing processes in the pharmacy and making changes to improve them and comply with SOPs. A professional standards assessor (qualified dispenser) who worked for the pharmacy superintendent's office was working in the pharmacy for two weeks to audit the processes and support the team. Both were leaving at the end of the following week. At the time of inspection there was also an experienced dispenser from another pharmacy, and a newly qualified dispenser who worked part-time. She had completed her accredited training in December but had some knowledge gaps. For much of her training time there had been insufficient team members to support her and coach her through learning some processes. For example, she had little knowledge of how to manage and assemble multi-compartment compliance packs as one person had previously undertaken this task. The two team members from England explained that before they left the following week, they intended to ensure that the remaining team members were trained and competent in all the pharmacy's processes. The two team members who had been off work were phasing back over the next two weeks. And a newly recruited team member was being trained in another branch before taking up the role in this pharmacy soon. At the time of inspection team members were able to manage the workload.

Recently the pharmacy had not been able to provide learning time during the working day for team members to undertake regular training and development. But it had provided team members undertaking accredited courses with additional time to complete coursework. The dispenser reviewing processes was monitoring and planning outstanding training modules on the Moodles platform. Team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. But pressures on time had limited this over recent months. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members used these to remind them to offer services to people who would benefit, for example texting people to notify them when their medicines could be collected.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are generally suitable for the pharmacy services provided. The pharmacy has appropriate facilities for people to have conversations with team members in private. But not all areas of the premises are as clean and well maintained as they should be.

Inspector's evidence

These were average-sized premises including quite a large retail area and a small dispensary. A team kitchen provided additional dispensary storage space. It was untidy in places. Some areas of the premises would benefit from cleaning. There were sinks in the dispensary, team kitchen and toilet. But the dispensary and toilet sinks were not in use. So, team members used the kitchen sink for dispensing activities and personal hand washing. It had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in the dispensary. The pharmacy did not have a fully professional external appearance. A shutter was closed when the pharmacy was open. And there was damage to the fascia. Team members explained that these issues had been shared with head office. The fascia had fallen last year and been reported. And the dispensary sink had been reported around three weeks ago. A team member who had worked in the pharmacy for two years did not recall the toilet sink ever working.

People were not able to see most activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer. Team members used it for administration tasks, and it was untidy. The door closed providing privacy. The door was kept locked to prevent unauthorised access. The pharmacy also had a separate area for specialist services such as substance misuse supervision. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy adequately helps people to access its services which it provides safely. Pharmacy team members mostly follow written processes relevant to the services they provide. They support people by providing them with suitable information and advice to help them use their medicines. And they provide extra written information to people taking higher risk medicines. The pharmacy obtains medicines from reliable sources and mostly stores them properly.

Inspector's evidence

The pharmacy had adequate physical access through a wide door and a low step. Some people using wheelchairs were not able to negotiate the step without help. The pharmacy had a buzzer for people to request help, but it did not work at the time of inspection. A team member described trying to get agreement to put in a ramp on the pavement. The pharmacy signposted people to other services such as blood pressure measurement. It had a hearing loop in working order for people wearing hearing aids to use. And it could provide large print labels for people with impaired vision. The pharmacy provided a delivery service.

Pharmacy team members followed a logical and methodical workflow for dispensing. They filed prescriptions in alphabetical order immediately on receipt so that they could find them easily if required. And they used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. The pharmacy sent much of the routine dispensing to an offsite hub to be assembled. Team members knew how to process these. The pharmacist undertook a clinical check before a dispenser submitted the prescriptions for processing. The dispenser highlighted any additions or changes of medication to the pharmacist to help with the clinical check. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The team had recently reviewed and improved this process. The pharmacy dispensed these around two weeks before the agreed date of supply. And the team was asking people for their mobile phone numbers and consent to text them when their medicines were ready for collection. Team members recorded the date the person collected their medicine, and the date the next supply was due. This ensured they dispensed the next supply in plenty of time. Pharmaceutical care needs' assessments were not being carried out in line with the service specification due to lack of consistency of pharmacists.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. A team member had recently reviewed and improved this process. She had re-written profile sheets for all people who received their medicines in these packs. This made it clearer for team members to see the medicines' supply history. And the team member had re-arranged the storage boxes making it clear which day the pharmacy supplied the packs, and when the packs were dispensed. As the team members were continuing to work through this process, they were including more detail on packs such as instalment number and date of supply. This reduced the risk of too many or too few packs being supplied. Team members

included tablet descriptions on packs and supplied patient information leaflets with the first pack of each prescription. The pharmacy supplied a variety of other medicines by instalment. Team members had also reviewed and improved this process. A team member dispensed these prescriptions in their entirety when the pharmacy received them. And included the date of supply on each label. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. And They were stored alphabetically in individually named baskets on labelled shelves.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. They supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. Team members appropriately described how they counselled people, including a scenario posed by the inspector. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, and emergency hormonal contraception (EHC). The locum pharmacist explained he had completed training and signed up to relevant PGDs in this health board area. The pharmacist dealt with Pharmacy First requests and undertook smoking cessation consultations. The pharmacy was not delivering other services such as weight management and blood pressure measurement due to lack of regular team members and inconsistency across the team.

The pharmacy obtained medicines from licensed wholesalers such as Phoenix, Alliance and AAH. The pharmacy mostly stored medicines in original packaging on shelves, in drawers and in cupboards. A team member immediately placed loose strips of tablets identified during the inspection into a receptacle for destruction. Team members mostly used space well to segregate stock, dispensed items, and obsolete items. A team member had reviewed and improved storage of some areas. But some shelves were untidy with different tablets, and different strengths of the same medicine stored together. The pharmacy stored items requiring cold storage in two fridges and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy still had some dispensed medicines on its shelves and in the fridge that should have been supplied several weeks or months ago. These included Fostair inhalers from September 2021 and diazepam tablets from December 2021. This could mean that people were not taking their regular medicine and this had not been checked. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to deliver its services. And it looks after the equipment to ensure it works.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy had equipment required to deliver pharmacy services. This included a carbon monoxide monitor maintained by the health board, although it was not in use currently as part of infection control measures. And a blood pressure meter which was calibrated as per the manufacturer's guidance. But the team was not using this as it did not have capacity to offer this service. The pharmacy kept crown-stamped measures by the sink in the dispensary and had separate marked ones for methadone. And the pharmacy used an automatic pump for measuring methadone solution. Team members cleaned it at the end of each day and poured test volumes when they set it up each morning. The pharmacy team kept clean tablet and capsule counters in the dispensary. It did not keep a separate one for methotrexate tablets as they were supplied in blister packaging.

The pharmacy stored paper records in the dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave them unattended unless they were locked.

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.