General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 22 Edinburgh Road, PENICUIK, Midlothian, EH26 8NW

Pharmacy reference: 1042770

Type of pharmacy: Community

Date of inspection: 06/10/2021

Pharmacy context

This is a community pharmacy on a main road in a town close to a city. 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 not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not identify and manage all the risks in the pharmacy. This includes storage of medicines, management of instalment prescriptions, and the management and assembly of multi-compartment compliance packs. Team members do not always follow written processes for the pharmacy's services.
		1.2	Standard not met	The pharmacy does not adequately monitor and review the quality and safety of its services including dispensing accuracy. Team members do not record dispensing errors. And they do not have processes in place to learn from these and reduce the risk of the same mistakes happening again.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have enough suitably qualified and skilled team members to safely deliver its services.
		2.2	Standard not met	Team members do not always have the appropriate knowledge, skills or competence relevant to their roles. There are some gaps in their knowledge about some processes. This introduces safety risks to people receiving some of the pharmacy's services including medicines supplied by instalment and in multi-compartment compliance packs. The pharmacy does not always provide sufficient supervision and development opportunities for team members.
		2.5	Standard not met	The pharmacy does not reassure team members who raise concerns that they are being appropriately dealt with.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy does not adequately manage all its services safely and effectively. This includes instalment dispensing, and medicines supplied in multi-compartment compliance packs.
		4.3	Standard	The pharmacy does not store all medicines

Principle	Principle finding	Exception standard reference	Notable practice	Why
			not met	safely and securely. Its shelves are untidy, some medicines are not stored alphabetically and are mixed with other medicines. It stores some loose strips of medicines on the dispensary shelves. And some medicines may not be fit for purpose as they have been removed from manufacturers' packaging for an unspecified time.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not adequately identify and manage all risks associated with its services. Team members do not follow written processes for all services and tasks, so there is a risk of mistakes. And they do not record or review any mistakes. So cannot identify learning points. This means the team members are missing learning opportunities and are not improving services. The pharmacy keeps the records that it needs to by law, but some are incomplete. Team members keep people's private information safe and help to protect vulnerable people. But they don't have access to all the contact information that would help with this.

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 and hand sanitiser at the medicines' counter. And it had labels on the floor to encourage people to socially distance. Most people coming to the pharmacy wore face coverings. Team members were not wearing masks at the start of the inspection, but one team member wore one when asked. The dispensary was spacious, so social distancing was possible some of the time. Team members were not observed to wash or sanitise their hands, or clean surfaces during the inspection. A cleaning spray was available.

The pharmacy had standard operating procedures (SOPs), but it was not clear which team members were following which processes. The pharmacy had a folder with printed copies of SOPs and team members' signatures from last year. Several signature sheets were in this folder for team members who no longer worked in the pharmacy. There were also sheets for two current team members. Others had read SOPs on the 'Moodles' platform, but team members could not access this at the time of inspection. The pharmacy did not have a manager or regular pharmacist, so no-one took responsibility for overseeing that team members had read and were working to relevant procedures. A team member believed there were SOPs that she had not yet read. The signature sheets seen had dispensers' signatures at each SOP, including England only and Wales only processes, electronic transfer of prescriptions (not applicable in Scotland) and accuracy checking of dispensed items and multi-compartment compliance packs. This suggested that team members had read and agreed to work to processes not relevant to their roles. The pharmacy superintendent's team reviewed them at least every two years and signed them off.

The pharmacy had 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. But they did not use them, and did not record any errors. There were no entries on the near miss log which was kept below the pharmacist's checking bench. And team members agreed they did not record errors. The locum pharmacist had identified an error during the inspection. An incorrect strength of medication had been dispensed. He explained that he intended to record it and try to discuss with the team member involved, but at that time he did not know who that was. As there was no information recorded, team members did not have the opportunity to identify any trends, learn from errors or make changes to reduce future risks. And they were not able to demonstrate any learning or changes made to reduce the chance of similar errors being made in the future. They were not able to review the safety and quality of their services easily.

The pharmacy had indemnity insurance, expiring 31 March 2022. It displayed the responsible

pharmacist notice and kept a responsible pharmacist log. This showed different pharmacists working each day over several months. And some did not record when they signed out of the pharmacy. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials certificates of conformity, but it did not record who it supplied these items to. This was required. It had controlled drugs (CD) registers with running balances maintained and regularly audited and one balance checked was correct. The inspector did not see a CD destruction register for patient returned medicines, so it was not known if all items were recorded as required.

Pharmacy team members described being aware of the need for confidentiality. The pharmacy had policies in the SOP folder, but they were not signed, so it was not known which team members had read them. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. The pharmacy did not have local processes or contact details available to raise safeguarding concerns. It had a local domestic abuse guide from 2006. And it had a poster in the consultation room with a number to contact for people suffering from domestic abuse. Team members had awareness of vulnerable people. The delivery driver described a situation when he raised a concern with pharmacy team members who contacted the person's GP. Team members also described action they had taken on several occasions for another person. They worked closely with the GP team to help keep the person safe and well.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always have enough qualified and competent team members to safely deliver all its services. And it does not set aside time for team members to continue their learning, so they find it difficult to keep their knowledge up to date. Team members make some decisions because there is no regular pharmacist to do this. And they raise concerns to try and keep the pharmacy safe, but it is not clear if these are suitably addressed. The team works hard to deliver its services.

Inspector's evidence

The pharmacy had one full-time and two part-time dispensers, one full-time trainee dispenser and a part-time delivery driver shared with another branch in the same small town. One of the part-time dispensers had been in the pharmacy for around two months, replacing a team member who had left after a long period of leave. This had left the pharmacy working with reduced numbers of staff for much of the time during the pandemic. It had not had a regular pharmacist for about two years, and there was no manager or leadership. There was a regular locum pharmacist one day per week, with a variety of locum pharmacists working the other days. Typically, there were three team members and a pharmacist working until 2pm, then two team members for the afternoon. The new dispenser worked two full days each week, so these days usually had four team members in the morning and three in the afternoon. But team members took it in turn to work Saturdays and taking a day off through the week. This work pattern was historic and resulted in some days having reduced staffing numbers. This was the case on the day of the inspection when one team member was on day-off and another was on annual leave. This meant there was only one team member and the locum pharmacist. Team members were not able to manage the workload. And they described not being fully trained and competent in all processes. During the inspection the team member who was on a day off came in to help. She was in the process of undertaking accredited training but was struggling to complete it as the pharmacy could not give her any protected learning time during the working day. And she did not have a tutor. The regular locum pharmacist helped. The trained dispenser present had been in the pharmacy around two years and completed her course during that time. However, she had not had a regular tutor and described several processes that she had not been fully trained and coached in. This included undertaking controlled drug running balance audits, some aspects of record keeping and processing of multi-compartment compliance packs. A team member who was not present had been trained in the processes related to off-site dispensing (MediPAC). She had then shown colleagues the process. Team members felt they could do the basics but might not be fully competent in all aspects of the process. The pharmacy did not provide any protected time for development, ongoing learning or reading new SOPs. A team member demonstrated that she was unable to access the ‘Moodle’ training platform where SOPs and training modules were accessed.

Pharmacy team members used a whiteboard to share relevant information about people and prescriptions. Team members said the information on it was current but there were no dates or team members’ names recorded against any messages. Team members were observed to work autonomously, for example phoning the GP practice to request re-prints of prescriptions. An example was observed, and a team member took personal responsibility for misplacing a prescription on a call to the GP practice. But the outcome was that the GP practice and pharmacy records did not match, so the GP practice issued a new prescription. This may not have been the most appropriate resolution, and it was not clear if a GP had been involved. The pharmacist had minimal input into this. Team members

raised concerns to the area manager and pharmacy superintendent's (SI) office about staff levels, but they felt this had not been resolved. The company had a whistleblowing policy. It set targets for various parameters.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitable for the services it provides. It has suitable facilities for people to have conversations with team members in private. And it is secure when closed. Team members raise maintenance concerns which the pharmacy addresses appropriately. The premises are adequately hygienic, but some areas including the floors and staff area are dirty.

Inspector's evidence

These were average-sized premises incorporating a large dispensary, limited storage space, and minimal staff facilities. There was nowhere for team members to sit during rest breaks. The sink in the staff area was dirty and had dirty dishes in and around it. The premises were appropriately maintained and contractors including a pest-control company visited annually. There was no evidence of rodent infestation according to recent reports. The dispensary floor would benefit from being brushed and washed. There were sinks in the dispensary, staff area and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in the dispensary and at the medicines' counter

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer, and the door closed providing privacy. As this room was quite small, team members did not take people into it. But some locum pharmacists used it. The pharmacy had an area at one end of the medicines' counter where people could speak to team members with a degree of privacy. The pharmacist supervised consumption of medicines here. Temperature and lighting felt comfortable throughout the premises. Some of the heaters had not been working recently. Team members had raised this, and an engineer repaired them during the inspection.

Principle 4 - Services **Standards not all met**

Summary findings

People can access the pharmacy's services. But the pharmacy does not always have adequate safeguards in place as team members do not follow written processes. And the pharmacy does not always have adequate checks in place to ensure people take their medicines as intended. The pharmacy obtains medicines from reliable sources but does not always store and manage them appropriately.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. The pharmacy could provide large print labels for people with impaired vision. And it provided a delivery service. Team members did not have badges showing their name and role. And they did not wear uniforms or company workwear, so they were not identifiable as pharmacy team members, and did not portray a professional image. They believed workwear had been ordered but was not available. So, people using the pharmacy could not differentiate between different roles and did not know who they were speaking to.

During the inspection a few walk-in prescriptions were dispensed by a dispenser then passed to the pharmacist to check. The pharmacy received prescriptions from the GP practices each afternoon then processed these, mostly to be dispensed by the off-site hub. Team members entered them on to the computer system then the pharmacist carried out clinical and accuracy checks before sending them electronically for dispensing. The pharmacy received the dispensed medicines two days later. Team members reconciled these with the original prescriptions which were filed by day of dispensing. They also placed any items which had been dispensed in the pharmacy with them. For items dispensed in the pharmacy, team members usually initialled dispensing labels to provide an audit trail of who had dispensed and checked the medicines. They placed baskets of dispensed medicines to be checked by the pharmacist, on shelves behind the pharmacist's bench. This kept the checking bench clear and clutter free to minimise the risk of mistakes at this stage. The pharmacy usually assembled owings the following day.

The pharmacy dispensed multi-compartment compliance packs on a four-weekly cycle. It kept master backing sheets for each person in folders for each week of assembly. But there was no other information observed such as records of medicine changes, hospital discharges or other interventions. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. The process was methodical and all packs were checked by a pharmacist before being supplied. But often they did not have prescriptions to dispense from. This was observed for several people's medication that had been assembled but the final accuracy check had not yet been carried out. A team member explained that this was not unusual as the GP practice would not supply prescriptions until the medicines were due. If the process was working smoothly, prescriptions would be requested at regular four-weekly intervals. The team members present had not seen the process managed in any other way. They attached A4 size backing sheets to packs with one staple, meaning the sheets were not adequately secured and could easly become detached, leaving the pack unlabelled. Backing sheets had brief tablet descriptions for most items. But the dates on all sheets inspected were wrong. For example, packs assembled this week (commencing 4 October) had commencement dates on backing sheets of 23/08, 30/08, 06/09 and 13/09 for one person. And 19/07, 26/07, 02/08 and 09/08 for another person. Team members did not write correct dates on any part of the packs. This would

provide incorrect information to any other healthcare professional looking at a person's medication, including during home visits or hospital admissions. The pharmacy supplied a variety of other medicines by instalment to a lot of people. They were stored alphabetically in individually named box files on dedicated shelves. Team members dispensed the instalments when the pharmacy received the prescriptions. But labels only had the date of labelling on them, and records were not kept of supplies being made. This was confusing and introduced risks of medicines being supplied twice. An example observed for a person to receive weekly instalments had three prescriptions in their box. The first prescription was dated 11 August and had a PC 70 form attached which would usually provide evidence of when medicines were due for supply and when the pharmacy supplied them. It showed that the first supply had been made on 16 August. Further supplies were noted to be due on 23 August, 30 August, and 6 September but there was no evidence of the pharmacy making these supplies. A second prescription was dated 6 September with no evidence of dispensing or supply. And a third prescription was dated 29 September and there were four dispensed instalments in the box, labelled on 30 September. Another example observed was for a person who should receive fortnightly instalments. Their labelled item showed the instalment date as well as the date of labelling. The instalment date was 28 September. The person had not collected their medication which had been due over a week ago. Team members did not review these prescriptions and therefore did not contact people had not collected their medication.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. The locum pharmacist was aware of the valproate pregnancy prevention programme and would provide advice if required. Team members were less familiar with it and did not know where the written information was kept. They were aware of a person in the high-risk category and thought that she had been given advice by another practitioner. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for the standard Scottish NHS services, but these were not seen. The locum pharmacist confirmed he was signed up to them all, and aware of the forthcoming training for a new service due to be launched the following month. The locum pharmacists delivered the Pharmacy First service which was not observed. Team members supplied lateral flow Covid tests to people who requested them. The pharmacy was not delivering any other services currently due to the inexperienced team and lack of regular pharmacist.

The pharmacy obtained medicines from licensed wholesalers such as Phoenix, Alliance and AAH. It stored medicines mostly in original packaging on shelves, in drawers and in cupboards. But some shelves were untidy with tablets not stored alphabetically, for example folic acid tablets were adjacent to sertraline tablets. Team members stored some loose strips of tablets on shelves, including two different items stored together (dihydrocodeine and cyclizine tablets), beside packets of omeprazole capsules and prednisolone tablets. And they had loose tablets removed from packaging and stored in amber bottles. Mostly these were labelled with expiry dates and batch numbers. But this was out with the product licences. And the dates of re-packing were not recorded so it was not known how long they had been stored in this way. Some packets of tablets in controlled drugs (CD) cabinets were badly damaged due to the way they were stored. The pharmacy stored items requiring cold storage in two fridges and team members monitored and recorded minimum and maximum temperatures daily. They were observed to within accepted limits. Team members did not regularly check expiry dates of medicines. Those inspected were found to be in date, but several items were close to their expiry dates, so if the pharmacy supplied them, they could be out of date by the end of a course of treatment. An example was a controlled drug expiring the following month. The pharmacy protected pharmacy (P) medicines from self-selection. No sales of medicines were observed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to deliver its services. And the team 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 kept equipment required to deliver pharmacy services in the consultation room although it was not currently delivering any additional services. It had personal weighing scales which had been calibrated recently and labelled for re-calibration September 2022. Team members kept crown-stamped measures by the sink in the dispensary and had a designated area for methadone measures. The pharmacy used a 'Methameasure' pump for measuring methadone solution. The pharmacist cleaned it at the end of each day and poured test volumes each morning. The pharmacy team kept clean tablet and capsule counters in various locations in the dispensary.

The pharmacy stored paper records in the dispensary and in folders in the consultation room 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.