General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 27 John Street, PENICUIK, Midlothian, EH26 8HN

Pharmacy reference: 1042772

Type of pharmacy: Community

Date of inspection: 16/05/2019

Pharmacy context

This is a community pharmacy in a town centre set amongst other shops. People of all ages use the pharmacy. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment compliance packs.

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 has some unmet risks caused by a lack of staff. These include a backlog of assembling multi-compartmental medicine packs.
		1.6	Standard not met	Some of the pharmacy's records are illegible. These include private prescription and controlled drug records which are legal requirements.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough staff to safely deliver its services.
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 deliver services safely and effectively. It does not have enough staff. So, it does not follow all processes in a safe timescale. And some dispensed medicines are not stored safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy team members mostly follow processes for all services to ensure that they are safe. But some processes are not followed in the usual way due to staff shortage. And some staff working in the pharmacy are not familiar with these processes. There is a risk of mistakes being made or medicines not being ready for people. Pharmacy team members sometimes record mistakes to learn from them. But they do not record all mistakes and may miss opportunities to prevent them happening again. The pharmacy keeps all the records that it needs to by law. But some of these records are illegible. The pharmacy usually keeps people's information safe. But some confidential waste is accumulating.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for all activities/tasks. All team members had read and followed SOPs relevant to their role. The pharmacy kept electronic records of this. The pharmacy reviewed SOPs every two years. The SOPs included roles and responsibilities. And there was a notice to this effect in the back-shop area.

The team members described the highest risk currently as staff shortages. The pharmacy was trying to manage this with additional pharmacists working – at the time of inspection there were three pharmacists working. The pharmacy had an audit trail in place for dispensed medicines in the form of dispensed and checked by signatures on labels.

The pharmacy was behind with the management of multi-compartmental medicine packs. A dispenser was assembling packs during the inspection that were due for supply the following day. She explained that under normal circumstances these would be done at least a week ahead. And, these were very poorly stored – some were on top of baskets of stock. Some were stored in box files which were not upright. Photographic evidence was taken.

The pharmacy had a business continuity plan in place to address maintenance issues or disruption to services. But this had not addressed the significant staff shortage being experienced.

The pharmacy kept near miss logs and team members recorded errors reaching patients. In the past, pharmacy team members had recorded most incidents, and these were reviewed monthly. But they did not always record incidents now due to pressures on resource. They had not reviewed these over the past two months until the regional team leader was investigating an error that had been brought to the attention of the General Pharmaceutical Council. They had implemented some changes including separating items with similar names and used shelf edge labels to highlight high-risk items.

Staff members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist.

The pharmacy had a complaints procedure. The pharmacy had indemnity insurance, expiring March 2020.

The following records were maintained in compliance with relevant legislation: responsible pharmacist

notice displayed; responsible pharmacist log; private prescription records including records of emergency supplies; and veterinary prescriptions. Some handwriting was illegible. Unlicensed specials records; controlled drugs registers, with running balances maintained and regularly audited. The pharmacist's handwriting was illegible. The inspector could not read the records. And a locum pharmacist was unable to read these. This meant that supply of medicines history could not be considered to assess any risk. Controlled drug (CD) destruction register for patient returned medicines. The pharmacy backed up the electronic patient medication records (PMR) each night.

Staff members were aware of the need for confidentiality. They had all read and signed the company information and policies. No person identifiable information was visible to the public. But confidential waste was collected in a large clear bag which was stored at the back door of the premises beside general waste. There was a high risk of this being discarded with general waste. Team members explained that it was usually shredded, but there was no time/staff to do this.

The pharmacy had company safeguarding information on a wall in the back-shop area. Team members had read this. And there were procedures in a patient safety folder. The pharmacists were PVG registered.

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

Summary findings

The pharmacy does not have enough trained and qualified staff to safely deliver its services. Team members discuss some incidents to learn from them. The pharmacy sometimes gives them time to read training material and new procedures.

Inspector's evidence

At the time of inspection, the pharmacy had two locum pharmacists, one regional lead pharmacist, one locum pharmacy technician, one part-time dispenser and one part-time medicines counter assistant working. After lunch that day the pharmacy had the three pharmacists and a part-time medicines counter assistant. So, it did not have any team members who were familiar with the pharmacy. This was challenging and chaotic.

The temporary regional lead pharmacist had an action plan in place to try and address staffing issues. (But the pharmacy was closed for part of the day after the inspection due to staff shortage. It had not notified relevant stakeholders). One of the locum pharmacists had worked in the pharmacy periodically over the past few months. He had noticed a decline in service delivery. He attributed that to staff shortages including absence. And challenges recruiting for a vacant post of an accuracy checking technician. This full-time post had been vacant for several months. There had been no additional accuracy checking cover. A part-time dispenser had started this week after a vacancy for several weeks.

Staff members were unable to manage the workload. e.g. they were not recording all near misses, and not reviewing these; they were beind with assembly of multi-compartmental medicine packs; the premises were untidy with some dispensed medicines poorly stored; confidential waste was not being destroyed promptly, and there was a reduction in staff training.

The pharmacy was providing some time for reading training material and new SOPs when possible. This was challenging. A team member described recently reading information about Syndol.

The few employed staff present during the inspection described the value of reporting and discussing mistakes. They knew this was useful for learning and reducing risk. But there was no time for reading material or discussing incidents. They had manged to discuss a dispensing error which had resulted in a complaint to the General Pharmaceutical Council (GPhC). Some changes had been made to minimise the chance of this happening again. This included putting a message on the patient’s electronic medication record. And separating the medicines involved.

Team members knew who to raise concerns with. They knew how to contact the pharmacy superintendent’s office and the NHS controlled drug accountable officer. A team member explained that the pharmacy manager had been asking for support with workload and staff shortage for several months. But there had been no or little support until the past two weeks.

Targets were set for various parameters but were not discussed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for its services. But it is untidy and cluttered. The pharmacy team members use a private room for some conversations with people. People cannot overhear private conversations. The pharmacy usually protects patient information. The pharmacy is secure when closed.

Inspector's evidence

The pharmacy premises are an unusual shape, being long and thin, and having access doors at either end. There were sinks in the dispensary, and toilet. These had hot and cold running water, soap, and clean hand towels. People were not able to see activities being undertaken in the dispensary. The pharmacy had put up a screen to prevent people seeing into the dispensary a few years previously. But this meant that team members working in the dispensary were unable to see the medicines counter or part of the retail area from the dispensary.

The premises were basically clean, but untidy and cluttered in some areas. The pharmacy had very little storage space. And some shelves contained archived records and obsolete stock including stockings and dressings. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers.
The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. Pharmacists used this room frequently for consultations and supervision of some medicines.

The pharmacy was alarmed, had CCTV, and panic alarms. Shutters protected both doors when the pharmacy was closed. A back door was protected by a gate.

Temperature and lighting were comfortable.

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

Summary findings

The pharmacy is not always able to open due to staffing difficulties. But it is busy and sometimes medicines are not ready as expected. The pharmacy team do not always provide safe services because they are short staffed. And some team members are not familiar with this pharmacy. They are rushing with some processes as there is a backlog. The pharmacy gets medicines from reliable sources, and mostly stores them properly. But some waste medicines are not properly stored. And the pharmacy does not meet the requirements of the Falsified Medicines Directive. Team members give people information to help them use their medicines correctly.

Inspector's evidence

There was good physical access by means of a level entrance and team members assisted people if required. The pharmacy displayed a list of its services. It had a hearing loop in working order available. Team members provided large print labels on dispensed medicines for people with impaired vision. The pharmacy had leaflets on a range of topics available.

Pharmacy team members followed a logical and smooth process for dispensing prescriptions. They were under pressure at times due to volume and lack of staff so sometimes this was chaotic and items waiting to be checked were accumulating. Team members were finding difficulty locating prescriptions for some patients. Some people were being asked to call back later if their medicines could not be located or were not ready. Some people were not waiting in the queue, but leaving the pharmacy, putting pressure on another pharmacy close-by. This was observed by the inspector at the other pharmacy.

The pharmacy had designated areas for dispensing and checking prescriptions. One area was designated for the management of multicompartmental compliance packs. The pharmacy managed these packs on a four-weekly cycle and assembled four at a time. But this area was small with little space for working on four packs at a time. A dispenser undertaking this task worked in a methodical manner and had adapted to the available space. The pharmacy was currently behind with this activity. Usually team members assembled these packs at least a week before the first supply was due. But at the time of inspection packs were being assembled for supply the following day. There was not enough stock available for some of these packs. Team members usually generated labels for these packs in advance and this generated stock orders. The dispenser was generating the labels on the same day as assembling packs, so some stock would not be available until the following day. This increased pressure as there was a rush to get these assembled.

The dispenser working on this process demonstrated awareness and concern of this and explained how she was working in a methodical manner to avoid mistakes. She openly described sometimes making mistakes, possibly because of not having time to check her work as thoroughly as usual. Tablet descriptions were on packaging, and patient information leaflets (PILs) were supplied with the first pack of each prescription. A part time dispenser with experience of managing these packs was largely responsible for them. But a colleague who was on annual leave at the time of inspection was trained and competent to deputise. A team member ordered prescriptions when the third pack was supplied. They checked prescriptions for accuracy and completeness before assembling packs and contacted prescribers for clarification if there was any ambiguity. Prescribers sometimes did not notify the

pharmacy of changes, but pharmacy team members always confirmed these before assembling trays. The pharmacy kept records of changes, although they did not always record prescribers' names. It also kept records listing packs to be supplied on different days. A dispenser laid out trays for delivery the following day before finishing work each day. Completed trays were stored in individual patient named boxes on designated shelves. But there was insufficient space on shelves and several of the boxes were randomly located on top of stock or other items.

Team members signed labels on dispensed medicines to provide an audit trail of who had dispensed and checked them. They usually assembled owings later the same day or the following day. There was a delivery service and signatures were obtained on receipt.

A dispenser poured methadone instalments once a week for the following week, and these were checked by a pharmacist. nstalments were stored in a controlled drug cabinet in baskets labelled with the date of supply. The locum pharmacists present during the inspection were aware of advice and counselling to be given to people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin.

NHS services followed the service specifications and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, chloramphenicol ophthalmic products and chlamydia treatment. These were current, and the pharmacists had been trained and signed them.

A locum pharmacist explained that there was no time to offer any pharmacy services except for dispensing.

The pharmacy stored patient returned medicines in receptacles which were provided and uplifted by an NHS contractor. But these were overflowing, posing some risk that obsolete medicines could become mixed up with stock.

Invoices were observed from licensed suppliers such AAH. The pharmacy did not comply with the requirements of the Falsified Medicines Directive (FMD). It had the equipment, but it was not yet functioning. Records of date checking and stock rotation were observed, but team members had not had time to do this for several weeks. Items inspected were found to be in date. The pharmacy stored medicines in original packaging on shelves/in drawers. And it stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. The pharmacy stored controlled drugs (CDs) in two CD cabinets. They used space well to segregate stock, dispensed items and obsolete items.

The pharmacy protected pharmacy (P) medicines from self-selection.
Team members usually followed the sale of medicines protocol when selling pharmacy medicines. The pharmacy had a list of 'red card substances' on the wall as an aide memoire for team members.
The pharmacy actioned MHRA recalls and alerts on receipt and kept records. It contacted people supplied with medicines on patient level recalls. And 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 for the delivery of its services. It looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had reference resources available. These included 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 a carbon monoxide monitor. The local health board maintained it. The pharmacy had Crown stamped measures. And separate marked ones were used for methadone.
Clean tablet and capsule counters were also kept in the dispensary. and a separate marked one was used for cytotoxic tablets.
The pharmacy stored paper records in the dispensary and back-shop areas. Archived records were on a shelf in a storage area. Team members never left computers unattended. They and were password protected. Screens were not visible to the public.

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.