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: 06/02/2020

Pharmacy context

This is a community pharmacy set among other shops in a town. 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.

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 team members follow written processes for all services to ensure they provide them safely. They record some mistakes to learn from them. And they make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to and keeps people's private information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs). Pharmacy team members read them, and the pharmacy kept records of this. They were in the process of reading some updated SOPs, which had to be completed by the end of the following week. The manager explained this target would be met. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy had a chart on the wall clarifying what the responsible pharmacist requirements were for the various pharmacy activities. Team members used this as reference when there was no pharmacist on the premises. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members sometimes used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They did not review these regularly as there was no regular pharmacist. But the non-pharmacist manager was aware of this and planning to address it soon. Team members discussed incidents and separated items in similar packaging.

The pharmacy had a complaints procedure that team members were aware of. It had an indemnity insurance certificate, expiring 31 March 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and 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. They were in the process of reading the relevant SOPs and information governance policies. They did this annually. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members had also read information on safeguarding. They had access to the process to follow to raise concerns. The locum pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough employed and locum staff to provide its services. Team members are all registered on appropriate training courses. They have access to other training material to ensure they have the skills they need. The pharmacy gives them some time to do this training during the working day. Team members share information to help keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time non-pharmacist manager/trainee dispenser who had been in the pharmacy for about four weeks; one full-time trainee dispenser who had been in the pharmacy for about five months and had come from another branch; one part-time new trainee medicines counter assistant who had started two weeks ago; one part-time (16 hours per week) trained medicines counter assistant; two delivery drivers shared with another branch. The pharmacy had booked locum dispensers for most days. And it had been using locum pharmacists, often different pharmacists each day, since the full-time pharmacist had left several months ago. It usually had two locum pharmacists one day per week. The pharmacy did not have regular trained/qualified dispensing team members. It usually had a pharmacist and three team members working at most times. At the time of inspection there was a locum pharmacist, the non-pharmacist manager/trainee dispenser, the full-time trainee dispenser, a locum dispenser and the trained medicines counter assistant. They were managing the workload. The pharmacy had recently recruited, and a new team member was expected to start in around two weeks' time. This person was new to pharmacy. An experienced accuracy checking technician had left the previous week and the pharmacy was recruiting to replace her. The staffing situation was challenging with a lack of pharmacist leadership and lack of continuity. Despite these challenges, most routine tasks were up-to-date including date checking and controlled drug running balance audits. Team members were not managing to dispense medicines from serial prescriptions in advance and did this when people arrived at the pharmacy. Some locum dispensers were not familiar with the computer system, so other team members spent time showing them how to use it. And some locum pharmacists were not familiar with the Scottish pharmacy contract and some were not signed up to deliver local services. The pharmacy did not have some processes embedded due to the lack of regular pharmacist. And this included the valproate pregnancy prevention programme which some team members were not aware of. And the NHS non-steroidal anti-inflammatory drug care bundle and sick day rules. The locum pharmacist and the manager were both aware of these.

The pharmacy provided learning time during the working day for all team members to undertake mandatory training/reading. They were currently working through updated SOPs. The manager had completed her accredited course while at another branch so just needed signed off. But this required being transferred to a new pharmacist tutor. But there was no permanent pharmacist in the pharmacy. The full-time trainee dispenser had been registered at the other branch but not yet started coursework. She also needed to be transferred to this branch and the new pharmacist. The ACT who had left the pharmacy recently had coached her through some processes. Team members were also required to undertake modules on different topics known as 'moodles'. They did these at work when there was time, but often had to do them at home. The manager asked the delivery driver to complete his either in the pharmacy or at home, whichever he preferred. This was observed. The locum pharmacist was supervising trainees.

The various individuals 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. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager or area manager. And they knew how to contact the pharmacy superintendent and the NHS controlled drug accountable officer. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. But team members did not use these to promote services to people. They only promoted services that people would benefit from and that they could deliver.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean, and suitable for the pharmacy services. The pharmacy team members can use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The premises were an unusual shape, being long and thin and having access doors at either end. 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. This was highlighted at the previous inspection last year. There was no mirror or CCTV covering that area which might improve visibility. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room 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 a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provides safe services. The pharmacy obtains medicines from reliable sources and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of one level entrance and another accessed down two steps. Team members assisted if necessary, and if they saw people needing help. But visibility was difficult from the dispensary. The pharmacy listed its services and had leaflets available on a variety of topics. But some of its signage was misleading for a pharmacy located in Scotland e.g. 'Did you know that NHS England are starting to restrict prescriptions for many products that treat common ailments?' The pharmacy sometimes signposted people to other services such as smoking cessation and services normally delivered under patient group directions. Some locum pharmacists were not signed up to local services e.g. recently a locum pharmacist from England could not continue to supply a person with Champix ®. The pharmacy had a hearing loop, that could be used with people wearing hearing aids. And it could provide large print labels to help people with impaired vision. Most team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. They placed dispensed medicines on 'retrieval rails', where they left them for up to four weeks. They contacted patients if they had not collected their medicine within that time. This was observed to be up-to-date. But there was a large number of bags of dispensed medicines. The inspector estimated around 250. The manager had reviewed how people's medicines were identified on these rails. She had produced an example showing where to attach labels and prescriptions to make it easier and therefore safer to locate people's medicines. She placed this on the pharmacist's checking bench for reference. This ensured that all pharmacists did it in the same way. The pharmacy had been experiencing delays getting prescriptions from the GP practice and had put a sign up to this effect. It stated '…surgery takes 5 days….' and further stated 'If you come in early it has a knock on effect and we get behind with everyone.' The pharmacy was expecting to start using an off-site dispensing hub the following week. Team members were due to receive training at that time. They had not told people about this service yet but expected medicines would take slightly longer to dispense than they were currently taking.

The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy usually dispensed these when they were due, before people came to the pharmacy. But it was not able to do this currently due to staffing challenges. Team members dispensed these items when people came to the pharmacy. They did not have a process in place to identify when these were due, so could miss the opportunity to address compliance issues.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four

assembled at a time, a week before the first pack was required. The pharmacy supplied some medicines in these packs with variable doses depending on blood test results. Team members assembled these as soon as they received the results, and this was often on the day of supply. They kept records of changes and other interventions. And they included tablet descriptions on backing sheets. The pharmacy dated all backing sheets with the same date i.e. although they supplied packs on four consecutive weeks, the 'commencement date' on the backing sheet was the same for all four. The spine of the packs had the instalment number but no reference to the date of supply. At the time of inspection (6 February) some were observed with 'commencement date' such as 3 January, and 9 January. This was confusing for locum team members unfamiliar with these patients. The pharmacy stored completed packs in labelled boxes on dedicated shelves in the dispensary. Team members stored prescriptions and patient records in these boxes. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these in entirety on receipt. And stored them in named boxes on shelves in the dispensary.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacist and manager were aware of the valproate pregnancy prevention programme and described how they would give advice. Not all other team members were aware of it, and no-one knew if a search for people in the 'at-risk' group had been done. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and chlamydia treatment. But not all locum pharmacists had signed these in this health board area, so some could not provide these services. The pharmacy team members referred requests for the minor ailments service to the pharmacist.

The pharmacy obtained medicines from licensed wholesalers such as Phoenix, Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge. The pharmacy monitored minimum and maximum temperatures and team members took appropriate action taken 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 protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. The pharmacy had a notice in the dispensary reminding team members to refer requests for 'red card substances' to the pharmacist.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records. 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 for the delivery of its services. It looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts 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 a carbon monoxide monitor which was maintained by the health board for use with people accessing the smoking cessation service. It also had crown stamped measures by the sink in the dispensary and had separate marked ones for methadone. And it had clean tablet and capsule counters in the dispensary including a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and back-shop area 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 never left 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.