General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, Farnham Centre for Health, Hale Road, FARNHAM, Surrey, GU9 9QL

Pharmacy reference: 1088791

Type of pharmacy: Community

Date of inspection: 08/01/2020

Pharmacy context

A busy community pharmacy based within a large health centre in a residential area of Farnham. The health centre consists of a small hospital, some clinics and three GP surgeries. The pharmacy opens five days a week. And most people who use it are patients of the health centre. The pharmacy sells a range of over-the-counter (OTC) medicines and dispenses NHS and private prescriptions. It supplies medicines to a few care homes and provides multi-compartment compliance packs (blister packs) to help people take their medicines. It delivers medicines to people who can't attend its premises in person. And it offers winter influenza (flu) vaccinations and a substance misuse treatment service.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy doesn't have enough team members to deliver its services safely and effectively. And it doesn't always have the right people working at the right time.
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 has procedures to help make sure its team works safely. It adequately monitors the safety of its services. It has appropriate insurance to protect people if things do go wrong. It mostly keeps all the records it needs to by law. And it asks people using its services for their views. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They identify and manage risks appropriately. They review the mistakes they make to try and stop them happening again. They understand their role in protecting vulnerable people. And they generally keep people's private information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. The SOPs were held in an electronic format. And they've been reviewed since the last inspection. The pharmacy's team members were required to read, sign and follow the SOPs relevant to their roles. But locum members of staff haven't been given an opportunity to read and sign the SOPs. The team members responsible for making up people's prescriptions used plastic baskets to separate people's prescriptions and to help them prioritise the dispensing workload. They referred to prescriptions when labelling and picking products. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by one of the pharmacists who also initialled the dispensing label. The pharmacy had systems to record and review dispensing errors and near misses. The pharmacy team had strengthened its dispensing process following a recent error with the assembly of a blister pack. Members of the pharmacy team recorded their mistakes. And they discussed and reviewed them periodically with their colleagues to learn from them and to try to stop them happening again. But they didn't always record the learning points from their reviews.

The pharmacy displayed a notice that identified the responsible pharmacist (RP) on duty. The roles and responsibilities of staff were described within the SOPs. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. They explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products to one of the pharmacists. A complaints procedure was in place and patient satisfaction surveys were undertaken annually. The results of last year's patient satisfaction survey were available online. The pharmacy's practice leaflet told people how they could provide feedback about the pharmacy. The pharmacy team asked people for their views. People's feedback led to the pharmacy trying to keep people's preferred makes of prescription-medicines in stock.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided through Numark. The address from whom a controlled drug (CD) was received from wasn't always included in the pharmacy's CD register. And sometimes correctional footnotes within the CD register were undated. But the pharmacy team tried to check the CD register's running balance regularly. The nature of the emergency within the pharmacy's electronic records for emergency supplies made at the request of patients sometimes didn't provide enough detail for why a supply was made. The pharmacy's RP records were generally kept in order. But sometimes the pharmacist forgot to record the time they stopped being the pharmacy's RP. The prescriber's details were occasionally incomplete or incorrect within the pharmacy's private prescription records. The date an unlicensed

medicinal product was obtained and, sometimes, when it was supplied and to whom weren't included in the pharmacy's 'specials' records.

The pharmacy had an information governance (IG) policy. And the pharmacy team was required to complete IG training. But some team members hadn't completed this training. The pharmacy had arrangements to make sure confidential waste was collected and then destroyed securely onsite. And its team tried to store prescriptions in such a way so people's names and addresses couldn't be seen by someone who shouldn't see them. But people's details weren't always removed or obliterated before patient-returned waste was disposed of. Safeguarding procedures were in place and contacts for safeguarding concerns were available too. Staff were required to complete safeguarding training relevant to their roles. And they could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

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

Summary findings

The pharmacy doesn't have enough team members to deliver its services safely and effectively. And it doesn't always have the right people working at the right time. Members of the pharmacy team are under pressure. They struggle to cope with the pharmacy's workload and complete all the tasks and training they're expected to do. But they make appropriate decisions about what is right for the people they care for. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy opened for 55 hours a week. It dispensed about 15,000 NHS prescription items a month. The pharmacy team consisted of a full-time pharmacist manager (the RP), a full-time dispensing assistant, two part-time dispensing assistants, a part-time trainee dispensing assistant and a part-time medicines counter assistant (MCA). A full-time dispensing assistant and an experienced MCA recently left the business. The RP has recently joined the pharmacy. And this was his first pharmacy management position. The long-term absence of the pharmacy's regular pharmacist was being covered by different locum pharmacists. The pharmacy also relied upon a locum pharmacy technician to cover a long-term vacancy. And her absence was currently being covered by a locum agency's dispenser. The RP, a locum pharmacist, a dispensing assistant, a trainee dispensing assistant and a locum dispenser were working at the time of the inspection. The company's Care Home Manager was also present to help with the pharmacy's care home workload.

The pharmacists were trying to clear a dispensing backlog of repeat prescriptions, check a care home due to be delivered that day and deal with people's urgent prescriptions and requests. The pharmacy team was under pressure throughout the inspection to do all the things it was expected to do. And team members were often interrupted during the dispensing process, including making up or checking people's blister packs, to help people or serve at the counter when no other team member was available. Queues of people quickly developed at the pharmacy counter throughout the inspection. There were inadequate contingency plans in place to make sure the right people were working at the right time despite team members raising their concerns about the level of staff cover to safely deliver the pharmacy's services. Members of the pharmacy team often worked outside of their normal working hours to try and cope with the pharmacy's workload. And they rarely got time to train, keep the pharmacy clean and tidy, and complete operational tasks. But they tried to help and support one another when they could. They felt the targets set for the pharmacy could be challenging at times. But they didn't feel their professional judgement or patient safety were affected by these. Medicines Use Reviews and New Medicine Service consultations were only provided by a suitably qualified pharmacist when it was clinically appropriate to do so and when the workload allowed.

The pharmacists supervised and oversaw the supply of medicines and advice given by staff. A member of the pharmacy team described the questions she would ask when making OTC recommendations and when she would refer people to a pharmacist; for example, requests for treatments for animals, infants, people who were pregnant or breastfeeding, elderly people or people with long-term health conditions. Staff performance and development needs were discussed informally throughout the year. Members of the pharmacy team were required to undertake accredited training relevant to their roles. They were encouraged to ask questions and familiarise themselves with new products. And they tried to complete training when they could or in their own time. Team meetings were held when the pharmacy wasn't

busy to update staff and share learning from mistakes or concerns. Staff felt they could make suggestions about how to improve the pharmacy and its services. And they knew how to raise a concern if they had one. Their feedback led to the changes in the way some tasks were rostered.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate and secure environment for people to receive healthcare. It has a room where people can have private conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy was located within a suitably-sized unit within the health centre. The pharmacy's premises were air-conditioned, bright, clean, secure and adequately presented. The pharmacy had enough workbench and storage space for its current workload. It had a separate area to assemble people's blister packs in. But this area was also used as the pharmacy's staffroom and stockroom. The pharmacy had a small consultation room for the services it offered and if people needed to speak to a team member in private. Conversations in the consultation room couldn't be overheard in the areas next to it. But it wasn't always locked when it wasn't being used. So, the pharmacy team needed to make sure its contents, such as a sharps bin, were kept securely. The pharmacy was cleaned most weeks by a cleaning contractor. But the cleaner wasn't left unsupervised within the pharmacy. And the pharmacy team was also responsible for keeping the registered pharmacy premises clean. The pharmacy had one sink and a supply of hot and cold water. It also had appropriate handwashing facilities for its staff too.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. The pharmacy provides services that people can access. It delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources and it mostly stores them appropriately and securely. Members of the pharmacy team generally carry out the checks they need to. So, they can make sure the pharmacy's medicines are fit for purpose. And they mostly dispose of people's waste medicines properly.

Inspector's evidence

The entrances to the health centre and the pharmacy were level with the outside pavement. So, people with mobility difficulties, such as wheelchair users, could access the building and the registered pharmacy premises. The pharmacy's services were advertised in-store and were included in the pharmacy's practice leaflet. Staff knew where to signpost people to if a service wasn't provided. The pharmacy offered a delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery. And people were asked to sign a delivery record to say they had received their medicines safely. The pharmacy had suspended providing blood pressure checks as there were no appropriately trained team members available to deliver the service.

The pharmacy provided a winter flu vaccination service. The pharmacy had valid, and up-to-date, patient group directions and appropriate anaphylaxis resources in place for this service. It kept a record for each flu vaccination. This included the details of the person vaccinated and their written consent, an audit trail of who vaccinated them and the details of the vaccine used. The pharmacy used a disposable and tamper-evident system for people who received their medicines in blister packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained within the blister packs. But it didn't always keep an audit trail of the person who had assembled and checked each prescription. And patient information leaflets weren't always supplied. So, sometimes people didn't have all the information they needed to make sure they took their medicines safely. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. Prescriptions were highlighted to alert staff when these items needed to be added or if extra counselling was required. But some assembled CD prescriptions awaiting collection were found to be over the 28-day legal limit. So, the pharmacy team needed to remove these to make sure no unlawful supplies were made. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had some valproate educational materials available.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius. It kept most of its medicines and medical devices within their original manufacturer's packaging. But some products weren't stored in an organised fashion. And some medicines had fallen onto the floor underneath the dispensary drawer system making it difficult to close the bottom drawers. Pharmaceutical stock was subject to date checks and its team documented these. The pharmacy stored its CDs, which were not exempt from safe custody requirements, securely. The pharmacy team was required to keep patient-

returned and out-of-date CDs separate from in-date stock. But patient-returned CDs have been allowed to build up and needed to be destroyed. The pharmacy team wasn't aware of the Falsified Medicines Directive (FMD). The pharmacy wasn't decommissioning stock at the time of the inspection. And members of the pharmacy team didn't know when the pharmacy would become FMD compliant.

Procedures were in place for the handling of patient-returned medicines and medical devices. Patient-returned waste was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. Pharmaceutical waste receptacles were available and in use. But the pharmacy didn't have a receptacle for the disposal of hazardous waste, such as cytostatic and cytotoxic products. Pharmaceutical waste receptacles, containing some opiate medicines, were found in a corridor that people could access. The pharmacy team promptly relocated these waste receptacles into a secure area of the pharmacy when the matter was brought to its attention. The pharmacy had a process in place for dealing with alerts and recalls about medicines and medical devices. And some OTC medicines subject to a recent drug recall were quarantined during the inspection. But the pharmacy team didn't always record the actions it took when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure its equipment is kept clean.

Inspector's evidence

The pharmacy had a range of clean glass measures. It had equipment for counting loose tablets and capsules too. And staff made sure the equipment they used to measure or count medicines was clean before using it. The pharmacy team had access to up-to-date reference sources. And it could contact its support office to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerators' maximum and minimum temperatures. Access to the pharmacy's computers and the patient medication record system was restricted to authorised team members and password protected. The computer screens were positioned so only staff could see them. A cordless telephone system was installed at the pharmacy to allow staff to have confidential conversations when necessary. The team members responsible for the dispensing process each had their own NHS smartcard. And they made sure it was stored securely when they weren't working.

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.