General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 617 Wakefield Road, Waterloo, HUDDERSFIELD, West Yorkshire, HD5 9XP

Pharmacy reference: 1089947

Type of pharmacy: Community

Date of inspection: 10/12/2019

Pharmacy context

The pharmacy is in a health centre in Waterloo, near Huddersfield. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). And, they provide medicines to people in multi-compartment compliance packs and deliver medicines to people's homes. The pharmacy provides a substance misuse 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 not all met	1.1	Standard not met	The pharmacy doesn't identify and manage key risks with its services. The team doesn't always work in the safest and most effective way. The pharmacy team are working under pressure to dispense a backlog of prescriptions. And so other tasks are not being completed fully or regularly.
		1.2	Standard not met	There is no evidence that pharmacy team members complete or share learning when they make mistakes. And, there is no evidence of any changes being made to improve and make pharmacy services safer.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy is not utilising the skills of its team to ensure the safe and effective provision of its services. Due to a backlog of work the available team members work under increased pressure and cannot complete the work in a timely manner. And they don't work in the most efficient way. The team are not completing other required tasks regularly or completely.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy has significant amounts of clutter on benches and floors in the area where prescriptions are prepared. And this means there is a significant risk of pharmacy team members tripping and falling over dispensing baskets on the floor. And, there is an increased risk of mistakes being made with the dispensing of people's prescriptions.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not adequately manage its stock ordering. And, this means the drawers where it stores its medicines are cluttered and overfull. There is an increased risk of mistakes being made whilst dispensing.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy doesn't always identify and manage key risks with its services. The team doesn't always work in the safest and most effective way. And it doesn't make use of the available technology to help manage the busy workload of dispensing prescriptions. The pharmacy team members generally record the mistakes they make during dispensing. But they don't take the time to complete and share any learning. And this means they miss opportunities to make changes in the way they work to reduce the risk of similar mistakes. The pharmacy team members generally follow the pharmacy's written procedures to complete their tasks. And they generally keep the records needed to by law. They protect people's privacy and confidentiality. And, they have the training and guidance to help safeguard children and vulnerable adults.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. Pharmacy team member accessed them electronically. The sample checked were last reviewed in 2019. And the next review was scheduled for 2021. Pharmacy team members had read and signed the SOPs since the last review. When asked about specific SOPs, pharmacy team members went to find a file of printed procedures. But, the manager explained she had been told to quarantine the file by the regional leader because all the procedures were now kept electronically online. Pharmacy team members were unsure about where to find the procedure on the company's intranet. This was discussed. And the manager agreed that she may not have communicated this point effectively to the rest of the team. She gave an assurance she would make sure that everyone knew where to find the procedures online. The pharmacy did not have any evidence that the pharmacist manager had read the procedures. She explained she had read the online procedures at another branch during her induction at the beginning of November 2019. But, she did not have a record in this pharmacy. The pharmacy defined the roles of the pharmacy team members in each procedure. The pharmacy had an accuracy-checking pharmacy technician (ACT) who was trained to perform a final accuracy check of prescriptions. The pharmacy had a documented procedure in place defining the role of the ACT. And, the ACT said that the boundaries of her roles had been further defined locally by discussion with the pharmacist. For example, she was able to check all prescriptions, except those for schedule 2 controlled drugs (CDs). The ACT explained her competence to check was revalidated every two years by the pharmacist. And, this was last completed in March 2019.

The pharmacy had access to the company's off-site dispensing hub, where they could send prescriptions to be dispensed to help ease their workload. But the pharmacy currently was not using the hub system. The pharmacist explained this was because she was not able to find the opportunity during the day to clinically check the prescriptions so they could be sent to the hub. So, she had instructed the pharmacy team members to label and dispense the prescriptions locally. Pharmacy team members said this was generating a significant backlog of work. The pharmacy had a significant amount of stacks of baskets containing dispensed items in various locations around the dispensary. Some were being kept on benches. And, others were being kept on the floor. The pharmacist said she was not able to check the prescriptions waiting in the baskets quickly enough because of the volume of people bringing prescriptions to the pharmacy to wait for them to be dispensed. And, pharmacy team members said they were finding people's prescriptions in baskets from these various locations as people came in to collect their medicines. And then the pharmacist was checking them whilst they

waited. Pharmacy team members explained that the current stacks of prescriptions in baskets had been waiting for at least three days to be checked. And, the inspector found baskets containing medicines that had been labelled on the 3 December 2019, seven days before the inspection. The ACT explained that she could not help to check any of the baskets because they had not been clinically checked by the pharmacist. Pharmacy team members showed the inspector three baskets full of prescriptions that had been downloaded that were waiting to be clinically checked and prepared. The baskets contained prescriptions that had been downloaded each day over the last three days. All three baskets were full of prescriptions. The pharmacist had asked pharmacy team members to label all the prescriptions and dispense them locally because she did not have time to clinically check them to send to the offsite hub to be dispensed.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. The pharmacy team discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. There current cause cited for making mistakes recently was the pressure they were under to deal with their backlog of work. The pharmacist said she was required to analyse the data collected about mistakes every month. But, she had not had the opportunity to do so since she started at the beginning of November because she had not had time. Pharmacy team members said that currently, there were not making changes after errors were made. They were made aware of the errors and trying to be more careful next time. The pharmacy had a process for dealing with dispensing errors that had been given out to people. Pharmacy team members recorded incidents using an online reporting system. Seven dispensing errors had been made since September 2019. Five of these had been documented. And, no record had been made of the causes of the error or any changes the pharmacy had made to prevent them happening again. Two error from October and November 2019 had not been investigated or documented. And, pharmacy team members said that no changes had been made since any of the errors to help reduce the risks of them happening again.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. The pharmacy had some feedback available from the last set of questionnaires analysed. But, pharmacy team members had not made any changes in response to the feedback to help improve their services.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. Pharmacy team members audited these against the physical stock quantity occasionally. From the records checked, the stock had been audited against the registers twice in November 2019. And, before that in August 2019. For example, the registers for Longtec 5mg tablets and Lynlor 5mg capsules. The balance in the methadone register was audited weekly. In November 2019, the pharmacy had identified discrepancies between the stock and the register for eighteen CDs. The manager said a pharmacist from head office was sent to resolve the discrepancies. And, he had been able to resolve them all. His investigation found that most related to medicines that had been dispensed but the supply had not been recorded in the register. The pharmacy kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record electronically. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It shredded confidential

waste. Pharmacy team members had been trained to protect privacy and confidentiality. They had read a file of policies about information governance and the General Data Protection Regulations (GDPR) in 2018 and 2019. Pharmacy team members clearly explained how important it was to protect people's privacy and how they would protect confidentiality.

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and adults. They explained how they would refer to the pharmacist. And, they showed procedures for children and vulnerable adults that were displayed on a noticeboard, including contact information for local safeguarding contacts. The pharmacist said she would assess any concern. And would refer to the company's head office for advice. Pharmacy team members completed mandatory training via e-learning every year. The pharmacist had last trained in 2017. And, she had recently been prompted by the company to renew her training by the end of December 2019.

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

Summary findings

The pharmacy is not utilising the skills of its team to ensure the safe and effective provision of its services. Due to a backlog of work the available team members work under increased pressure and cannot complete the work in a timely manner. And they don't work in the most efficient way. They have the right qualifications for their roles and the services they provide. And, they mostly keep their skills up to date by completing ongoing training.

Inspector's evidence

There was an adequate number of staff working on the day if there had not been a backlog of work. And if the team could have utilised the services of the offsite dispensing hub. But the team members were clearly working under pressure and were not able to complete the day's work and also complete the backlog of work. There were other tasks such as CD balance checks that they were not completing as regular as they should. They were not utilising the skills of the team members. Many prescriptions had been dispensed that the accredited pharmacy technician (ACT) could not check. And the pharmacist couldn't dedicate time to complete clinical checks on the system to allow some of the workload to be dispensed at the offsite hub. The team members described the pressure they felt with the backlog of work, the number of recent changes and the implementation of the company's new offsite hub dispensing. The pharmacist manager had been in post since November 2019. And due to the backlog of work had struggled to improve ways of working. And effectively implement changes in process. She concentrated day to day on completing the dispensing workload.

The pharmacist and pharmacy technicians were subject to revalidation as part of the professional registration. All pharmacy team members were also required to complete training via online e-learning modules sent by head office periodically. But, they were all behind with their training requirements. The manager showed a list of outstanding training for the pharmacy team members that the area manager had sent her. The outstanding modules for most team members included training about safeguarding, look-alike and sound-alike (LASA) medicines, sepsis and risk management. Pharmacy team members said they had not had the opportunity to complete their training because they had been so busy. And, under pressure to complete their work and manage the backlog. A pharmacy team member said they had been struggling to keep up with their training requirements since October 2019. The pharmacy had an appraisal process. But, pharmacy team members said they had not received an appraisal since August 2018, when they had a pharmacy manager. They said they had not had manager since, until their new manager had started in November 2019. They explained that since their previous manager had left, they had not had the opportunity to raise or address any issues or learning needs with anyone.

The pharmacist had raised some concerns with the regional leader and the superintendent pharmacist's (SI) office. And, they were aware of the situation and had provided an extra pharmacist to help on odd days. But, she said the resource of an extra pharmacist had not been in place long enough to make a difference to the backlog. The pharmacy had a whistleblowing policy. And pharmacy team members knew how to access the procedure if necessary. Pharmacy team members communicated with an open working dialogue during the inspection. The pharmacy asked the team to achieve targets in various areas of the business. The pharmacist said she had discussed targets with the regional leader. And, they had agreed to suspend the pharmacy's targets because they were struggling to meet them

whilst dealing with the current issues in the pharmacy.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is generally suitable for the services provided. But the area where the team dispenses prescriptions is untidy and cluttered. There is a significant risk of the team tripping and falling over the baskets they use for dispensing. And there is an increased risk of the team making mistakes whilst dispensing. The pharmacy is clean and secure. And, it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The dispensing area in the pharmacy was cluttered. Most of the pharmacy's bench space was taken up with stacks of baskets of dispensed medicines. This limited further the small amount of bench space available for the volume of dispensing being done. And, stacks of baskets of dispensed medicines were also being kept on the floor, significantly increasing the risk of trip hazards. And the stacks of baskets of dispensed medicines significantly increased the risk of mixing up people's prescriptions and medications. There was a clearly defined checking area for both the pharmacist and accuracy-checking technician to use. The rest of the pharmacy was clean and well maintained. The retail area was tidy and well organised. The pharmacy stored stock on shelves and in drawers throughout the premises. The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises, excluding the dispensing area, was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

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

Summary findings

The pharmacy sources its medicines from licenced suppliers. But it doesn't always store and manage its medicines appropriately. It overfills the storage drawers with medicines. And different medicines are mixed together. This increases the risk of the team making mistakes whilst dispensing. The pharmacy provides services that support people's health needs. And it generally manages its services appropriately. The pharmacy keeps records of deliveries it makes to people's homes. So, it can deal with queries effectively. Pharmacy team members take steps to identify people taking high-risk medicines. And, they provide these people with suitable advice. But they don't always have the required printed information to give to people.

Inspector's evidence

The pharmacy had level access from the street and the surgery reception area. Pharmacy team members explained they would communicate in writing with people with a hearing impairment. And, they could provide large-print labels to help people with a visual impairment.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. And they used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And, she checked if the person was aware of the risks if they became pregnant while taking the medicine. She also checked if they were on a pregnancy prevention programme. But the pharmacy did not have stock of printed information material to give to people to help them manage the risks. The pharmacy supplied medicines in multi-compartment compliance packs when requested. It attached labels to the packs, so people had written instructions of how to take their medicines. Pharmacy team members added descriptions of what the medicines looked like, so they could be identified in the pack. And provided people with printed information leaflets about their medicines each month. The pharmacy team documented any changes to medicines provided in packs on the patient's master record sheet. Most packs were checked for accuracy by the accredited pharmacy technician (ACT). She explained that because of the current backlog of work, thy had recently been checking packs on the day they were due to be supplied to people. The pharmacy's usual process was for the pharmacist to clinically check the prescriptions first. Then, the packs would be dispensed and assembled ready for the technician to perform the final check. The technician explained that currently, packs were being assembled and checked for accuracy before the pharmacist had seen the prescriptions. Then, they were left for the pharmacist to clinically check before being supplied to people. This was still in accordance with the pharmacy's documented procedure for preparing multi-compartment compliance packs. The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy to arrange a re-delivery. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet.

The pharmacy obtained medicines from three licensed wholesalers. Some pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They explained that a member of the head office training team had visited the pharmacy to provide them with training. But they had not had time to complete the training during the visit because they had been so busy. The pharmacy had the necessary equipment and software available to scan complaint packs of medicines.

But pharmacy team members said they were not routinely scanning products. The pharmacy stored medicines on shelves and in drawers in restricted areas of the pharmacy. The drawers were very full and disorganised. And, during the inspection, a further 18 totes of stock arrived from wholesalers. Pharmacy team members said the arriving stock was for prescriptions they had labelled over the last three days. And, they had not had time to check whether the pharmacy already had the required stock. So, they had ordered the stock just in case. They said they frequently owed people commonly used items. The inspector observed several areas in the drawers where look-alike and sound-alike medicines were mixed up together in the same location. One example was a compartment where isosorbide mononitrate, isosorbide dinitrate, indapamide and irbesartan were all mixed together. Pharmacy team members said they were aware of the issue, But had not had time to tidy and organise the drawers. The pharmacy had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinets tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. Two products were correct. But a discrepancy was found with Lynlor 5mg capsules.

Pharmacy team members were required to check medicine expiry dates every 12 weeks. And, some records of checks were seen. They had last completed a full check of the pharmacy's medicines in July 2019. And had started again to check medicines in December 2019. But, pharmacy team members said they were struggling to complete the proper checks because of lack of time. They highlighted any short-dated items with a sticker on the pack up to three months in advance of its expiry. And, removed these if they expired before the next date check was due. After checking some medicines on the shelves and in drawers, the inspector did not find any medicines that were out of date. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. Pharmacy team members kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well maintained measures available for medicines preparation. It positioned computer terminals away from public view. And, it protected the computers with passwords. It stored medicines waiting to be collected in the dispensary, also away from public view. And, it had a dispensary fridge, which was in good working order. Pharmacy team members used the fridge to store medicines only. They restricted access to all equipment. And, they stored all items securely.

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.