General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hockley Pharmacy, 5-7 Broad Parade, HOCKLEY, Essex, SS5 5DA

Pharmacy reference: 1031195

Type of pharmacy: Community

Date of inspection: 15/08/2019

Pharmacy context

The pharmacy is located on a small parade of shops in a residential area, with a surgery within about a five minutes' walk. And the people who use the pharmacy are mainly older people. It receives around 90% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews and the New Medicine Service. It supplies medication in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 largely identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. It largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), and near miss and dispensing incident reporting processes. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. The last entry on the near miss log was in January 2019. The pharmacist said that there had been near misses since then but these had not been recorded on the log. He said that he would keep the log in the dispensary and not in the consultation room so that it was readily accessible and used more frequently. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred when incorrect directions had been written on a dispensing label. The person had taken some of the medicine and had need to seek medical assistance. The pharmacist said that the pharmacist who had made the error was informed and had to re-read and sign the SOPs. The incident was reported on the National Reporting and Learning System.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would open if the pharmacist had not turned up. He knew that he should not hand out dispensed items or sell pharmacy-only medicines until the pharmacist had arrived. But he thought that he could sell some general sales list medicines. He said that he would not carry out any dispensing tasks until the pharmacist had arrived. The inspector reminded him what he could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed special was made. Private prescription records were completed correctly. But the nature of the emergency was not routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at the time of dispensing. Methadone balances were checked weekly; overage was recorded in the register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The correct responsible pharmacist (RP) notice was clearly displayed and the RP log was largely completed correctly. But there were several occasions where the RP had not completed the log when they had finished their shift.

Patient confidentiality was protected using a range of measures. Confidential waste was removed by a specialist waste contractor, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed General Data Protection Regulation training.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop area and results from the 2017 to 2018 survey were available on the NHS website. Results were positive and 98% of people who responded had rated the pharmacy as excellent or very good overall. The seating area was commented on in the survey as being an area for improvement. The pharmacist said that plans had been drawn up for a minor refurbishment and additional seating would be installed in the shop area. The complaints procedure was available for team members to follow if needed and details about it were displayed in the shop area. The pharmacist said that he was not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy since he started working at the pharmacy around three years ago. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. And they can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets. Team members are not always provided with regular ongoing training. This could make it harder for them to keep their skills and knowledge up to date.

Inspector's evidence

There was one pharmacist and two dispensers working on the day of the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The dispenser appeared confident when speaking with people. He was aware of the restrictions on sales of pseudoephedrine containing products. And said that he would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The dispensers had completed accredited pharmacy courses and some certificates were displayed in the dispensary. The dispenser said that team members were not provided with ongoing training on a regular basis, but they did receive some. The pharmacist said that the pharmacy had recently received some information about CBD. He ensured that all team members were aware that it was not for medicinal use and how best to help people who asked to buy it.

A person had complained about not having enough of their medicine. The pharmacist dealt with the person in a calm manner and said that he would request a prescription for that one medicine so that the person would then receive four weeks for all of their medicines next time they were ordered. This would help the person manage their medicines and reduce the number of times they had to visit the pharmacy to collect their medicines.

The dispenser said that information was passed on informally between team members. He said that during a recent meeting, team members had discussed the repeat prescription process and how to improve it. The previous system had been hand-written and it was now managed on the patient medication record. The dispenser said that this had made it easier to track which items had been ordered and when. Team members appeared comfortable about raising concerns. The pharmacy had a meeting with the local surgery every three months to discuss any pharmacy issues or problems with getting medicines. The pharmacist said that the pharmacy had a good relationship with the surgery and this helped to ensure that people were given the best service possible.

Targets were not set for staff. The pharmacist said that he provided the services for the benefit of the people who used the pharmacy. And he would not let targets affect his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air-conditioning was available; the room temperature was suitable for storing medicines. There were the chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area. But there was an open view into the consultation room. This may pose a risk to privacy, particularly if a person removed an item of clothing. The pharmacist said that he would arrange for the window to be covered. The room was being used to store some delivery boxes and medicines. The pharmacist said that this was only temporary as the store room was being fitted out so that it could be used to assemble the multi-compartment compliance packs. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages its services well and provides them safely. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. The pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available.

The pharmacist said that the surgeries issued prescriptions for people taking higher-risk medicines once the relevant blood tests had been carried out. He confirmed that the pharmacy did not record the blood test results they were made aware of. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for these medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that he would ensure that these prescriptions were highlighted in future and record was kept of any checks made by the pharmacy. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these items possibly being handed out after the prescription had expired. The pharmacist said that he would highlight these in future. The pharmacist said that the pharmacy supplied valproate medicines to a few people. And there were a few people in the at-risk group who needed to be on the Pregnancy Prevention Programme. Some of the valproate packaging came with warning cards attached. But the pharmacy did not have spare cards. The pharmacist said that he would order more from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every six months and this activity was recorded. Stock due to expire within the next six months was marked. Items were removed from dispensing stock three months before they were due to expire. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Part-dispensed prescriptions were checked twice a day. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. There were only a few part-dispensed prescriptions at the pharmacy. The pharmacist said that uncollected prescriptions were checked every two months and people were contacted if they had not collected their items. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. The pharmacist said that the patient's medication record was updated.

Prescriptions for people receiving their medicines in multi-compartment compliance packs were

ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that people contacted the pharmacy when they needed them. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not obtain people's signatures for deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. The pharmacist said that he would ensure that signatures were obtained where possible in future. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist said that he and other team members had undertaken some training on how the system worked. And there were written instructions on the process. The pharmacist said that the pharmacy would likely start using the equipment fully in September 2019.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Some suitable equipment for measuring medicines was available. Separate plastic liquid measures were marked for methadone use only. The pharmacist said that he would order suitably calibrated measures. Triangle tablet counters and tweezers were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

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.