General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hawkwell Pharmacy, 212 Main Road, Hawkwell, HOCKLEY, Essex, SS5 4EG

Pharmacy reference: 1031198

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. The people who use the pharmacy are mainly older people. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, flu vaccinations, Health Checks (blood pressure and cholesterol). It is involved with a pilot project funded by the National Pharmacy Association called the community pharmacy hypertension service. It provides multi-compartment compliance packs to small number of people who live in their own homes to help them manage their medicines.

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

Inspector's evidence

The pharmacy adopted some of measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Medicines in similar packaging or with similar names were separated where possible. And the areas where these medicines were kept were highlighted. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. The person had noticed the mistake before taking the medicine and had returned it to the pharmacy. The pharmacy supplied the correct medicine and completed an incident report. The pharmacy reported incidents to the National Pharmacy Association and they received a report every three months to show common mistakes.

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 trainee dispenser said that the pharmacy would open if the responsible pharmacist (RP) had not turned up. She knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. But she thought that she was allowed to sell general sales list medicines before the pharmacist had arrived. The inspector reminded her what could and shouldn't be done if the pharmacist had not turned up. She said she would not carry out any dispensing tasks if the pharmacist was not signed in.

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. The emergency supply record was completed and there were signed in-date patient group directions for the services offered. The prescriber's full details were not always recorded in the private prescription record. The pharmacist said that they would ensure that the record was completed in future. Controlled drug (CD) registers examined were filled in correctly, and the pharmacist said that CD running balances were checked at regular intervals and at the time of supply or receipt. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The correct RP notice was clearly displayed. And the RP log was largely completed correctly. But the pharmacist had completed the log before finishing his shift on the day of the inspection. And there

were alterations made to the RP record. But there was no audit trail to show when these changes had been made or by whom. This could make it harder for the pharmacy to show who had made the alteration if there was a query.

Patient confidentiality was protected using a range of measures. Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards 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 training on the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop area and were available on the NHS website. Results were positive and 100% of respondents rated the pharmacy as excellent or very good overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The trainee dispenser said that she had referred a person to the pharmacist who she had concerns about and said that she had the person's consent before discussing with the pharmacist. The person was referred to the appropriate safeguarding agency. And a record of the concern was kept at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they are provided with protected training time. This means that they are able to complete this training at work. They can raise any concerns or make suggestions and this means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist and one trainee dispenser working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The trainee dispenser had completed an accredited medicines counter assistant course and was enrolled on an accredited dispenser course.

The trainee dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. She said that she 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. She knew that a person needed to have a consultation with the pharmacist before they could buy Viagra Connect.

The pharmacist said that team members had access to online training modules. And he said that he actively encouraged them to complete the training. The trainee dispenser said that team members were allowed time during the day to complete training. Team members had recently completed dementia training with the Local Pharmaceutical Committee and completed yearly influenza vaccination training. The pharmacy had a healthy living champion and it regularly promoted various campaigns. A recent campaign was about anti-biotics, and the upcoming campaign was about stop smoking. The pharmacy updated the health promotion stand each month. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The pharmacist kept detailed records of interventions. He had recently contacted a prescriber to query a prescription. A person had been prescribed more than the maximum dose of a medicine which may have potentially interacted with another medicine that they were taking. A different medicine was prescribed as a result of the pharmacist’s intervention.

The trainee dispenser said that she had a good working relationship with the pharmacist and she could suggest changes to the pharmacy when needed. She felt supported with making any changes. The pharmacist said that there were no formal meetings and information was passed on to team members informally. He said that team members had informal appraisals but these were not documented.

Targets were not set for staff. The pharmacist said that the pharmacy provided services for the benefit of people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises 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 was one chair in the shop area. This was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The pharmacist said that extra chairs were available if needed.

The consultation room was accessible to wheelchair users and was located next to the medicines counter. It was suitably equipped and well-screened. The door was not kept secured when the room was not in use, but the room was not accessible from the shop area. Low-level conversations in the consultation room could not be heard from the shop area.

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

Overall, the pharmacy provides its services safely. It gets its medicines from reputable suppliers and largely manages them well. 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.

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 were available. The pharmacy offered a blood pressure monitoring service where people were loaned a blood pressure monitor from the pharmacy for 24 hours. People monitored their own blood pressure and returned the monitor to the pharmacy. Results were checked by the pharmacist and the person's GP was informed. The National Pharmacy Association provided training for the pharmacists. The pharmacist said that people usually had to wait around two months for this service from the NHS before the pharmacy started providing it. He said that people who may benefit from the service were identified by the pharmacist or referred from their GP. An appointment system was used for the travel vaccination clinic so that people attended when a suitably qualified person was available.

The pharmacist said the surgeries would not usually issue a prescription for higher-risk medicines such as methotrexate and warfarin, if the person needed a blood test. The pharmacy kept a record of blood test results. This made it easier to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 CDs were highlighted, but prescriptions for Schedule 4 CDs weren't highlighted. The pharmacist said that he would ensure that these were also highlighted to help minimise the chance of these being handed out after the prescription was no longer valid. The pharmacist said that people taking valproate medicines were provided with warning cards and patient information leaflets. He said that the pharmacy supplied valproate medicines to one person in the at-risk group. But they did not need to be on a Pregnancy Prevention Programme.

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. Several medicines were found which were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. This could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The packs found were removed from dispensing stock during the inspection and placed for disposal.

The pharmacist said that 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, but until they were collected. This could make it harder for team members to refer to the original prescription and could

potentially increase the chance of errors. The pharmacist said that he would ensure that a copy of the prescription was kept with the dispensed items in future. The pharmacist said that uncollected prescriptions were checked monthly. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. And the person'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. There was an audit trail to show who had dispensed and checked each pack and the backing sheets were attached to the trays. But the additional cautionary and advisory warnings were not on the backing sheets. Medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were not routinely supplied. This could make it harder for people have up-to-date information about how to take their medicines safely. The pharmacist said that he would ensure that the information leaflets were supplied in future and he confirmed that the cautionary and advisory warnings would be added to the backing sheets.

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 member of the pharmacy team. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that other people's information was protected. 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 had undertaken some training on how the system worked, but the dispenser had not yet done the training.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely.

Inspector's evidence

Suitable equipment for measuring medicines was available. Triangle tablet counters 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 pharmacist said that the blood pressure monitors were replaced every two years. The carbon monoxide testing machine was calibrated by an outside agency. The weighing scales and the shredder were in good working order. 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.