General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hobbs Pharmacy, Holmesdale Road, South Darenth, DARTFORD, Kent, DA4 9AF

Pharmacy reference: 1032695

Type of pharmacy: Community

Date of inspection: 27/06/2019

Pharmacy context

The pharmacy is in the centre of a small village near to a surgery. It is part of a small chain of pharmacies and is co-located with a Post Office. The nearest large town is Dartford which is around a 15 minute drive away. The people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews and the New Medicine Service. It provides multi-compartment compliance aids to around 40 people who live in their own homes to help them take their medicines safely. And it provides substance misuse medications to two people.

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 met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	Damaged flooring in the shop area and dispensary is a significant tripping hazard to team members and people who use the pharmacy.
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 generally identifies and manages the risks associated with its services. It largely protects people's personal information. And it seeks feedback from the people who use the pharmacy. It largely keeps its records up to date. 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. There were up-to-date standard operating procedures (SOPs). Team members had signed the SOPs to indicate that these had been read and understood.

Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. There were a few near misses recorded on the log. But the pharmacist said that she had not recorded most of them. Some previous near miss logs had been reviewed but recent ones hadn't. The pharmacist said that she would encourage team members to record their own mistakes which may better help them to learn from them. She also confirmed that near miss logs would be reviewed for patterns.

Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The pharmacist said that she would inform the pharmacist who made the error so that she could reflect on how to minimise the chance of a similar mistake. The person the medicines were for had noticed the error before using the medicine and they had returned it to the pharmacy for it to be changed.

Workspace in the dispensary was limited. 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 apprentice said that the premises would open if the pharmacist had not turned up as the Post Office would need to be accessible. She was aware that she should not sell pharmacy only medicines but she thought that she could sell general sales list medicines. She thought that she could hand out dispensed items if they had been checked by the pharmacist and thought that she could carry out dispensing tasks. The pharmacist said that she reminded team members not to sell pharmacy only medicines or hand out dispensed items when she was not in the pharmacy. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance in place. 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 prescriber's details were not routinely recorded in the private prescription record. The pharmacist said that she would ensure that this was completed correctly. The emergency supply record was completed correctly.

Controlled drug (CD) running balances were checked around once every three months and at the time of dispensing. Liquid CD 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 responsible pharmacist (RP) log was largely completed correctly. But there were several occasions when one of the pharmacists had not signed out when he finished his shift. The pharmacist said that she would remind that person to complete the log correctly. The correct RP notice was clearly displayed.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Dispensed items waiting collection could not be viewed by people using the pharmacy. The pharmacist used her own Smartcard to access the NHS electronic services. She said that this was secured at the end of the working day. Other team members did not have their own Smartcards. This means that the pharmacy may not be able to access NHS electronic services at times. The pharmacist said that she would request cards for other team members.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2017 to 2018 survey were available on the NHS website. Results showed that 96% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to refer to if needed. The pharmacist said that she was not aware of any complaints at the pharmacy.

The pharmacist said that she had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Some team members had completed safeguarding training provided by the pharmacy. The apprentice 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 pharmacist said that there had been a recent incident involving an older person and she had contacted the police. She said that the person was looked after by them and was grateful for her involvement.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. Team members are provided with some training to help keep their skills and knowledge up to date. And they can raise any concerns or make suggestions to help make the services safer.

Inspector's evidence

There was one regular full-time pharmacist, one pharmacy technician, and two apprentices working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The apprentice appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And 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.

The pharmacy technician said that she completed continuing professional development modules and uploaded these to the GPhC website. She said that she had completed the revalidation process. The pharmacist had recently completed refresher training on the influenza vaccine. Team members had recently completed some training on over-the-counter medicines use in pregnancy. The pharmacist said that she had completed all training required to provide the services offered. And had completed consultation skills training and declarations of competence for the services.

The pharmacist said that information was passed on informally within the team. But there were no formal meetings. She said that team members did not receive formal appraisals or performance reviews but that this was done informally on an ad-hoc basis. She said that she would consider formalising these in future. Team members appeared to have a good working relationship with the pharmacist. They said that they felt confident to raise any issues with her.

Targets were set for Medicines Use Reviews. The pharmacist said that she did not feel under pressure to reach the targets. And she provided these services for the benefit of the people who used the pharmacy. She confirmed that she would not let targets affect her professional judgement.

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

Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services. But damaged flooring in the shop area and dispensary is a significant tripping hazard to team members and people who use the pharmacy.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was co-located with a Post Office. Pharmacy only medicines were kept behind the counter. The pharmacist had a clear view of the medicines counter and shop area from the dispensary. Air-conditioning was available; the room temperature was suitable for storing medicines.

The floor in the dispensary did not appear to have been cleaned for some time and it was dirty. The carpet was worn and frayed in places. Some carpet tiles had been placed on the flooring to the side of the medicine counter leading to the dispensary and these were loose and unsecured. This may pose a tripping hazard for team members. The surround on the flooring immediately inside the main door had become damaged. The pharmacist said that the metal surround had been removed. The flooring had been taped down but the tape was worn and damaged, and it presented a potential tripping hazard for people using the pharmacy. The pharmacist said that the carpet was usually vacuumed regularly. But she confirmed that the floor near the sink had not been cleaned for some time. The sink in the dispensary was not clean. The pharmacist said that she would arrange for a deep clean of the pharmacy.

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 consultation room was accessible from the shop area. Low-level conversations in the consultation room could not be heard from the shop area. The windows in the doors were not see-through. There were two chairs and a small desk available. The room was accessible to wheelchair users. Excess stock of prescription only medicines was kept in the room. A large fridge was in the room with prescription only medicines in. Some bulk prescription items with prescriptions were kept in the room. The pharmacist said that people were not left in the consultation room unsupervised and the room was kept locked when not in use. 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

People with a range of needs can access the pharmacy's services. The pharmacy largely 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 to use.

Inspector's evidence

There were two steps up 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 pharmacist said that she checked monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. But a record of results was not kept. This could make it harder for the pharmacy to monitor people's previous blood test results. Prescriptions for schedule 3 and 4 CDs were highlighted. But prescriptions for high-risk medicines weren't. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said CDs and fridge items were checked with people when handing them out. She said that all people in the at-risk group who were taking valproate medicines were provided with warning cards and patient information leaflets. There were a couple of people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacist had annotated this on their medication record.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next few months was marked. A few medicines were found which were not kept in their original packaging. And the packs they were in did not include the date that they had been removed from their original packaging. This could make it more difficult for the pharmacy to know if these were safe to use.

The pharmacist said that part-dispensed prescriptions were checked daily. '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 medicines were collected. Uncollected prescriptions were checked monthly. Items uncollected after around two months were returned to dispensing stock where possible. And the person's medication record was updated. The pharmacy kept a list of these items so that people could be informed if they went to collect their medicine. Prescriptions for CDs were returned to the prescriber and other prescriptions were shredded in the pharmacy.

Prescriptions for people receiving their medicines in multi-compartment compliance aids were ordered in advance so that any issues could be addressed before they needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that people usually ordered these when they needed them. The pharmacy kept a record for each person which included any changes to their medication. They also kept hospital discharge letters for future reference. Compliance aids were suitably labelled and there was an audit trail to show who had checked each compliance aid. But there was no audit trail to show who had dispensed them. The pharmacist said that

she would remind team members to initial the backing sheets. This would help to identify which team members had been involved if there was a mistake. Compliance aids were suitably labelled but the backing sheets were not attached to the compliance aids. This could increase the chance of them being misplaced. The pharmacist said that she would ensure that these were attached. Medication descriptions were put on the compliance aids. And patient information leaflets (PILs) 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 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. The CD cabinet keys were held securely and there were arrangements in place to safeguard the CD keys overnight.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible; but these were not recorded in a way so that another person's information was protected. The pharmacist said that she would discuss this with the driver an implement a better process to ensure that other people's information was not visible when signatures were recorded. Failed deliveries were returned to the pharmacy before the end of the working day. A card was left at the address instructing the patient to contact the pharmacy to rearrange delivery.

Licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. A record of any action taken was kept, which showed what the pharmacy had done in response.

The pharmacy had the equipment installed ready for the implementation of the EU Falsified Medicines Directive. The pharmacist said that it was not in use and team members had not yet received training. But these were things that had been considered.

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. Separate measures were marked for CD use only. 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 monitor had been in use for around two months. The weighing scales and shredder were in good working order. The phone in the dispensary was portable so 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.