General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hodgson Pharmacy, 59 Station Road, Longfield, DARTFORD, Kent, DA3 7QA

Pharmacy reference: 1032704

Type of pharmacy: Community

Date of inspection: 16/04/2019

Pharmacy context

The pharmacy is a family run independent business located on high street opposite a surgery in a large village in Kent. The people who use the pharmacy are mainly older people. The pharmacy uses a dispensing robot to dispense most of the medicines. It provides multi-compartment compliance aids to several people who live in their own homes and provides substance misuse medications to a few 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	1.4	Good practice	The pharmacy actively seeks feedback from people using the pharmacy and makes changes to improve services.
2. Staff	Good practice	2.2	Good practice	Team members are provided with ongoing and structured training to support their learning needs. They can complete training during the working day and this is checked by the pharmacist.
		2.5	Good practice	The pharmacy seeks feedback from team members and the superintendent pharmacist allows changes to be made.
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 generally identifies and manages the risks associated with its services. It generally protects people’s personal information. And it keeps records up to date. It actively seeks feedback from the public and makes changes to improve services when needed. 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), near miss and dispensing incident reporting and review processes. Team members had signed to indicate that they had read and understood the SOPs. 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 trends and patterns. There were very few near misses, likely due to the use of the dispensing robot. An electronic near miss log had been implemented which prompted team members to include more information about the type of error. And what action had been taken to minimise the risk of a similar error.

Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the medicine had been labelled with the incorrect directions. The person had been admitted to hospital for an unrelated problem. They had continued to take the dose they had been taking before and did not follow the instructions on the label. A member of the hospital team noticed the labelling error. The superintendent (SI) pharmacist reported the incident on the National Reporting and Learning System.

The pharmacy had a check list for tasks which had to be completed, daily, weekly, monthly, quarterly, bi-annually and annually. Team members initialled next to the tasks they had carried out. The pharmacy carried out several audits regularly. Including a quarterly 'owings’ audit, an annual waiting time audit and clinical audits. A recent audit was carried out on the use of non-steroidal anti-inflammatory drugs (NSAIDs). The SI said that he had sent letters to people's GPs to remind them about the use of medicines such as proton pump inhibitors (PPIs) alongside NSAIDs. He said that there had been an increase in PPI prescribing alongside long-term use of NSAIDs.

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. The pharmacy technician (accuracy checking technician (ACT)) knew which prescriptions he could accuracy check as the pharmacist marked prescriptions which had been clinically checked. He knew that he should not be checking medicines if he had been involved in any part of the dispensing process.

Team members' roles and responsibilities were specified in the SOPs. The ACT said that the pharmacy would not open if the pharmacist had not turned up. He said that he would attempt to contact the pharmacist or the SI. He said that he would not carry out any dispensing tasks until the pharmacist had arrived. The dispenser knew that she should not hand out bagged items or sell pharmacy only

medicines if the pharmacist was at lunch.

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. Signed in-date patient group directions were available for the services offered. The private prescription record and emergency supply record were completed.

Controlled drug (CD) running balances were checked around once a month and at the time of dispensing. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) record was generally compliant. But there was one occasion where the pharmacist had signed out of the log instead of recording it as an absence. The SI said that this was due to the RP clicking on the wrong button and this could not be amended on the computer. The pharmacist said that during the lunch hour no dispensing tasks were carried out and only general sales list medicines were sold. They remained on the premises and were still responsible during lunchtime. 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. Smart cards used to access the NHS spine were stored securely and team members used their own Smart cards during the inspection. Bagged items awaiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed General Data Protection Regulation training and level 1 data security awareness training online.

The pharmacy carried out yearly patient satisfaction surveys; results were available on the NHS website and in the shop area. Results showed that 99% of respondents rated the pharmacy as very good or excellent overall. The pharmacy had a mystery shopper around once every three months. The most recent visit from the mystery shopper showed that the pharmacy achieved 97%. The SI replied to all comments on the NHS website. He said that the pharmacy had not received any complaints in the last four years. Records were kept for all complaints and the SI responded in writing to the person who had complained. The complaints procedure was available for team members to follow if needed. The SI said that recent surveys had highlighted the potential need for additional seating in the waiting area. He said that this was considered during the refit and extra chairs were added.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy. Including the CPPE training on children's oral health and Dementia Friends training. The 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 SI said that there had not been any safeguarding concerns at the pharmacy for around six years.

Principle 2 - Staffing ✔ Good practice

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. They can raise any concerns or make suggestions and have regular meetings. 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. These are not affected by the targets it has. The team members discuss adverse incidents and use these to learn and improve. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. They are given time set aside for training. This means that they can complete this training at work.

Inspector's evidence

There was one regular pharmacist, one ACT, one dispenser and one apprentice working during the inspection. The SI arrived at the pharmacy at the start of the inspection. The team wore smart uniforms with name badges displaying their role. 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. He was aware of the restrictions on sales of pseudoephedrine containing products. He said that he would refer to the pharmacist if a customer 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 customer. A list of questions was available at the medicines counter for team members to refer to when needed.

All new members of the team had to complete an induction which included elements about health and safety and customer care training. The SI said that all team members were enrolled on the Healthy Living Champion training. Team members completed regular online training on an electronic tablet. The SI checked which training had been completed. He said that he encouraged all team members to progress from medicines counter assistant to dispenser. And for them to complete training so they could provide the enhanced services. Each member of the team had an individual training folder and kept certificates for all learning. Team members were allowed time during the working day to complete training. Staff were paid for training time to attend external events.

The pharmacist was trained to carry out some of the enhanced services, including: Medicines Use Reviews (MUR), the New Medicine Service (NMS), travel services, influenza vaccine. The SI was trained to carry out all the enhanced services. Both had completed declarations of competence and consultation skills training. The SI was an independent prescriber for medical aesthetics. He was a voluntary member of Save Face and said that he had received an inspection in February 2019. He ran the clinic from the pharmacy. But this was a separate business.

The SI said that there were team meetings held each week to discuss any positive or negative feedback, errors reported or to share learning. He shared the weekly NPA superintendent report and discussed targets. He regularly worked at the pharmacy and team members felt confident to raise any issues with him. The pharmacist said that she had suggested rearranging the medicines and other items in the shop area. The SI agreed to the change for a trial period. The dispenser had implemented a list of codes for the robot, to help minimise the time taken to find medicine codes on the computer. Team members

had yearly appraisals and performance reviews. With informal review processes when needed.

Targets were set for MUR, NMS and other services. The superintendent pharmacist said that targets were realistic, easily achieved and under constant review. He said that the services were provided for the benefit of the people using them.

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. The dispenser said that the pharmacy underwent a refit around five years ago. Air-conditioning was available; the room temperature was suitable for storing medicines. There were four wipe clean chairs available in a waiting area. These were positioned out of view of the medicines counter to help minimise the risk of conversations at the counter being heard. Pharmacy only medicines were kept behind the counter.

The consultation rooms were accessible from the shop area. Low level conversations in the rooms could not be heard from the shop area. The door to room one was not kept locked when not in use, but confidential information was kept securely. The room was accessible to wheelchair users. The table could be moved if needed. There were two chairs and a stool available with a sink. And the sharps bin was accessible. The door to room two was left unlocked when not in use. This left some confidential material and medicines potentially unsecured. The door to the store room at the rear of the pharmacy was left unlocked and open during the inspection. Medicines and prescriptions were kept in this room. The SI said that he would ensure that both consultation rooms and the store room were kept locked when not in use.

Toilet facilities were clean and there were separate hand washing facilities available. Medicines for destruction were segregated from stock. But the SI said that there was little room to store a designated bin for storing waste medicines in the dispensary. So, the designated bin was kept in the toilet area. This could allow unauthorised people to potentially access these medicines.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers. And it generally manages its services well. 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 was step free access to the pharmacy through a wide entrance. The pharmacy team had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. A variety of patient information leaflets were available. Services and opening times were clearly advertised. The induction hearing loop appeared to be in good working order.

The SI said that he checked monitoring record books for people taking high risk medicines such as methotrexate and warfarin. Results were recorded on the patient's medication record. Prescriptions for schedule 4 CDs were not highlighted. This could increase the risk of these medicines being supplied when the prescription has expired. The pharmacist said that dispensed fridge items were shown to people when handing out. The pharmacist said that all people taking valproate medicines were provided with warning cards and patient information leaflets when needed. There were currently no people who needed to be on a pregnancy prevention programme.

Stock was stored in an organised manner in the dispensary. Expiry dates for prescription only medicines and pharmacy only medicines were checked monthly and this activity was recorded. Short-dated items were recorded in a book. Medicines were kept in appropriately labelled containers. The dispensing robot ejected expired medicines when prompted. The dispenser added exact expiry dates to the system when medicines were placed in the robot.

The SI said that part dispensed prescriptions were checked daily. 'Owings' notes were provided, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. He said that uncollected prescriptions were checked monthly; items uncollected after around two months were returned to dispensing stock where possible. There was a dental prescription in the retrieval system which did not have a date on it; this had been dispensed and was waiting collection. The SI said that he would return the prescription to the prescriber for the date to be added. A private prescription in the retrieval system did not have the prescriber's address recorded. The SI said that he would remind team members to check the validity of prescriptions before accepting from people.

The pharmacy did not order prescriptions on behalf of people who received their medicines in multi-compartment compliance aids. The pharmacy kept a record for each patient 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 dispensed and checked each compliance aid. Medication descriptions were put on the compliance aids. Patient information leaflets (PILs) were routinely supplied.

CDs were stored in accordance with legal requirements. 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 pharmacist made deliveries to people. The pharmacy obtained people’s signatures for deliveries where possible; these were recorded in a way so that other people's information was protected. Items were only delivered to people who could not collect their medicines from the pharmacy.

Only licensed wholesalers were used for the supply of 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.

The SI said that the software had been installed on the computers and the pharmacy had the authorisation code in preparation for the implementation of the EU Falsified Medicines Directive. But the pharmacy was waiting for the equipment to be ordered.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. 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 methotrexate use only. This helped avoid any cross-contamination.

The blood pressure monitor was calibrated by an outside agency. The Smokerlyzer was calibrated by an outside agency. The weighing scales were in good working order. All equipment in the pharmacy had been electrically tested by an external agency. 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. The external thermometer was not in good working order. But the SI had a replacement available.

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.