General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hobbs Pharmacy, 41-43 Wells Road, Marlow Park, Strood, ROCHESTER, Kent, ME2 2PW

Pharmacy reference: 1032915

Type of pharmacy: Community

Date of inspection: 26/09/2019

Pharmacy context

The pharmacy is located on a parade of shops surrounded by residential premises. The people who use the pharmacy are mainly older people. The pharmacy receives around 85% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, a stop smoking service (nicotine replacement therapy and Champix), the NHS Urgent Medicine Supply Advance Service, a needle exchange service and the Online Non-Prescription Ordering 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 adequately identifies and manages the risks associated with its services to help provide them safely. It regularly seeks feedback from people who use the pharmacy. The pharmacy largely protects people's personal information. And it generally keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. Team members understand their role in protecting vulnerable people, but some may benefit from some additional training about safeguarding.

Inspector's evidence

The pharmacy adopted adequate 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 were in the process of reading the recently updated SOPs.

Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. There had not been any near misses recorded between January and August 2019. There had been some recorded in September. The responsible pharmacist (RP) said that she would encourage team members to record their own near misses and then she would review these regularly for any patterns. Items in similar packaging or with similar names were separated where needed. The second pharmacist said that she was not aware of any recent dispensing incidents. She said that dispensing incidents would be recorded on a designated form and a root cause analysis would be undertaken.

Workspace in the dispensary limited. However, 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 pre-registration trainee said that the pharmacy would open if the pharmacist had not turned up. She knew that she should not sell pharmacy-only medicines or hand out dispensed items, but she thought that she could sell general sales list medicines before the pharmacist had arrived. The inspector reminded her what she could and should not 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 medicine was made. And there were signed in-date Patient Group Directions available for the relevant services offered. Not all the private prescription records had the correct prescriber's details recorded. This could make it harder for the pharmacy to find out these details if there was a future query. 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 frequently. Liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The RP log was completed correctly most of the time. But there were several

occasions where the pharmacist had not completed the log when they had finished their shift. The correct RP notice was clearly displayed.

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 overnight. At the start of the inspection team members were using a smartcard which belonged to a team member who was not working during the inspection. This was discussed with team members during the inspection and the pharmacist said that smartcards would not be shared in future. Bagged items waiting collection could be viewed by people using the pharmacy and people's personal information was visible. These were turned around during the inspection by the team members so that people's personal information was not visible.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2019 survey were available on the NHS website. Results were positive and 100% of respondents were satisfied with the staff overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The RP said that she was not aware of any complaints.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The pre-registration trainee and trainee dispenser said that they had not completed any safeguarding training. The pre-registration trainee could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The second pharmacist said that there had not been any safeguarding concerns at the pharmacy. 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. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There were two pharmacists, one pre-registration trainee and one trainee dispenser working during the inspection. Team members had either completed accredited pharmacy courses or were enrolled on a course for their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she confirmed 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 pre-registration trainee said that she felt supported by the superintendent pharmacist and the pharmacists. She worked at two pharmacies within the organisation, and felt that working at this pharmacy allowed her more time to ask questions and learn because it was not as busy. She had learned how to input information about influenza vaccinations on to PharmOutcomes and how people qualified for the injection from the NHS. She had been involved with the supervised consumption service and how to make entries into the CD register. She explained that she had been working on the medicines counter in order to gain experience with listening to people's symptoms and when to refer to the pharmacist.

The pharmacists were aware of the Continuing Professional Development requirement for the professional revalidation process. They were in the process of carrying out a handover and takeover to ensure that the new pharmacist was confident with all the processes and procedures. One pharmacist was leaving and another was due to take over as the pharmacy manager. The RP had printed out the GPhC decision making framework so that she could have a better understanding of the standards expected for the pharmacy.

The second pharmacist had completed declarations of competence and consultation skills for the services offered, as well as associated training. The RP said that she was in the process of completing the influenza training. The pharmacy had recently received a link to an online training package provided by the pharmacy's head office. The training modules did not appear to be fully accessible yet. But the RP said that each team member would eventually have their own log in and she would monitor the training. And certificates would be issued when team members had completed a certain number of modules.

The RP said that she would be carrying out appraisals and performance reviews for team members every six months. She had worked at the pharmacy for around three weeks at the time of the inspection. Team members said that they felt comfortable discussing any issues with the pharmacist.

The RP said that she could discuss any issues with the superintendent pharmacist.

The pre-registration trainee said that there was a meeting held when she and another member of the team had started working at the pharmacy around three months ago. She said that this was to ensure that they understood the procedures and what was expected of them. She said that information was usually passed on informally and a communications book was used to ensure that people who were not at work at the time of the discussion could have access to important information. The pharmacy received regular updates from the superintendent pharmacist.

Targets were set for Medicines Use Reviews and the New Medicine Service. The second pharmacist said that she did not feel under pressure to achieve the targets and she would not let these affect her professional judgement.

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 generally tidy. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacists 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 a large shop area and a small dispensary area. There was limited workspace in the dispensary and this was cluttered with baskets, leaving very little room for dispensing. This was discussed with the pharmacists and the superintendent pharmacist during the inspection. The consultation room was used for assembling multi-compartment compliance packs. This could pose an issue if a person wished to discuss something in private when people’s personal information was visible. The RP said that she would ensure that people’s information was not visible and that the room was kept locked when not in use.

There were three 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. Some bags of dispensed medicines were not kept securely. And some people’s personal details were potentially visible on them at the medicines counter. These were moved by team members during the inspection.

The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area. The room was not kept secure when not in use at the start of the inspection.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available. There was a light flickering in the shop area. The RP said that this had been reported and was waiting to be fixed.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. But 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.

rescriptions for higher-risk medicines such as methotrexate and warfarin were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that she did not routinely check monitoring record books for people taking higher-risk medicines. And did not check that people were having regular blood tests. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But she was not aware of any people in the at-risk group who needed to be on the Pregnancy Prevention Programme. Most of the boxes for valproate medicines had the warning cards attached. But the pharmacy did not have additional patient information leaflets or warning cards available. The pharmacist said that she would order replacements from the manufacturer. Prescriptions for Schedule 3 and 4 CDs were highlighted, to help minimise the chance of these medicines being handed out when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pre-registration trainee said they checked CDs and fridge items with people when handing them out.

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 three months was marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Part-dispensed prescriptions were checked regularly. '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 not kept at the pharmacy until the remainder was collected. This could make it harder for team members to refer to the original prescription when handing out. Uncollected prescriptions were not regularly checked. The RP said that these should be checked monthly and only kept for three months. But there were several expired prescriptions in the retrieval system. This could increase the chance of these being handed out when the prescription was no longer valid. The RP said that uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. She confirmed that prescriptions would be kept at the pharmacy until the medicines were collected in future.

Assessments for the people who had their medicines in multi-compartment compliance packs were not currently being carried out. The RP said that she would contact the surgeries and arrange assessments for people, to show that it was needed. Prescriptions for people receiving their medicines in these 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 second pharmacist said that she thought that people usually ordered these when they needed them. The dispenser who managed the packs kept a record of who the pharmacy ordered on behalf of and monitored how much they had received. 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 obtained people's signatures for deliveries where possible and these were recorded in a way so that another person'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 and it was being used. Team members had undertaken training on how the system worked and there were written procedures.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were marked for methadone 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 second pharmacist was not sure how long the blood pressure monitor had been in use for. She said that she would ensure that a sticker was placed on the new machine to indicate when it was to be replaced. The carbon monoxide testing machine was calibrated by an outside agency. The shredder was 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.