

Registered pharmacy inspection report

Pharmacy Name: A.E. Hobbs Ltd., 72 Mount Pleasant, TUNBRIDGE
WELLS, Kent, TN1 1RJ

Pharmacy reference: 1033007

Type of pharmacy: Community

Date of inspection: 05/06/2019

Pharmacy context

The pharmacy is located on a busy high street in a town centre surrounded by residential premises. It provides a variety of services, including Medicines Use Reviews and the New Medicine Service. And it supplies multi-compartment compliance aids to around 30 people who live in their own homes. The people who use the pharmacy are mainly older 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 generally identifies and manages the risks associated with its services. It generally protects people's personal information. And it actively seeks feedback from people who use the pharmacy. The pharmacy largely keeps the records it needs to by law. 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. Near misses were highlighted with the team member involved at the time of the incident; they generally identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for trends and patterns. Dividers were routinely used to separate items in similar packaging. Some medicines with similar names were separated and highlighted. A recent incident had occurred where the wrong type of medicine had been supplied to a person. A record had been made in the book. But it did not contain a detailed account of the event or which person the medicine was for. The superintendent (SI) pharmacist said that a note had been made on the patient's medication record (PMR). He confirmed that he would use the PMR incident reporting system to record dispensing incidents.

Work surfaces in the dispensary were 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 pharmacist had not turned up. She said that she would not hand out any bagged items until he arrived. But she thought that general-sales-list medicines could be sold before he had arrived. And she thought that she could carry out dispensing tasks. She referred to a list of tasks on the wall in the dispensary. This explained the level of supervision required for each task. The trainee medicines counter assistant (MCA) knew that she should not sell pharmacy only medicines or hand out bagged items if the pharmacist was not on the premises. She knew that if the pharmacist did not return after two hours then she would not be allowed to sell general-sales-list medicines.

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 private prescription record was generally completed correctly. But a couple of private prescriptions did not have the prescriber's address recorded. 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 a medicine was supplied if there was a query. Controlled drug (CD) running balances were checked around once a month. 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 completed correctly. And 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 waiting collection could not be viewed by people using the pharmacy.

The pharmacy carried out yearly patient satisfaction surveys. And results were available on the NHS website. The results from the 2017 to 2018 survey showed that 100% of respondents were satisfied with the pharmacy overall. A complaints procedure was available. The pharmacist said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The trainee dispenser could not recall having had any safeguarding training. But she 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 he had not had to refer any people on to them.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They can raise any concerns or make suggestions. This means that they can help improve the systems in the pharmacy. They discuss adverse incidents and use these to learn and improve.

Inspector's evidence

There was one pharmacist (SI), one pharmacy technician, one trainee dispenser, one MCA and one trainee MCA working during the inspection. The team wore smart uniforms with name badges displaying their role. Visitors working in the pharmacy were asked to wear a 'visitor' badge to show that they were not part of the pharmacy team. The team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. 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 trainee dispenser had completed the medicines counter course and was enrolled on an accredited dispenser course. The pharmacy technician said that she started working at the pharmacy around 20 years ago. She had started as a part-time counter assistant and progressed onto become a dispenser and then a pharmacy technician. She said that she completed continuing professional development and had submitted these during the revalidation process. The MCA said that she read booklets that she received from suppliers. But she was not provided with any structured training by the pharmacy. The SI said that the MCA had only recently completed the counter assistant course. And he would look to provide her with ongoing training. She said that she had not had a performance review or appraisal since starting at the pharmacy around 10 months ago. The SI said that he would review team members performance informally. But he would look to document these reviews.

The trainee MCA said that team members who worked on the medicines counter routinely left messages for each other to ensure that tasks were completed. The MCA said that there were no formal team meetings. But there were informal daily chats to delegate tasks and ensure that any issues were discussed. Team members felt confident to discuss any issues with the SI. Targets were not set. The pharmacist said that he carried out services for the benefit of the people using the pharmacy and only when appropriate.

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 and clean throughout; this presented a professional image. Air-conditioning was available; the room temperature was suitable for storing medicines. There was one wipe-clean chair in the shop area. There were many bagged items kept on the floor in the dispensary. These could have posed a tripping hazard to team members. And made it difficult for team members to pass each other which disrupted the workflow. The pharmacy technician placed most of these into a plastic box to help clear the space. The SI said that there weren't usually that many bagged items and they usually fitted into one box which did not get in the way. He said that he would consider keeping these items in the room to the rear of the dispensary.

People using the pharmacy could approach the dispensary counter where team members were dispensing prescriptions. The pharmacist had a clear view of the medicines counter from the dispensary. He could listen to conversations at the counter and intervene where needed.

The consultation room was accessible from the shop area. The door was kept locked when not in use. Low-level conversations in the consultation room could not be heard from the shop area. The glass door was see-through. The SI said that he would ensure that this was covered so that people's privacy would be protected while they use the room. There were two chairs, a desk and a small sink was available. The room was accessible to wheelchair users. There was a small hatch from the consultation room to the dispensary.

There was a large kitchen and rest room area downstairs. 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. And the pharmacy generally manages its services well and provides them safely. It gets its medicines from reputable suppliers, and 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 SI said that the floor in the shop area had been raised during the last refit of the pharmacy. So that people did not have to walk down two steps to enter the premises. This allowed better access for wheelchair users and others who were less able to use steps. The pharmacy team had a clear view of the main entrance from the medicines counter and dispenser. They could help people into the premises where needed. Services and opening times were clearly advertised. And a variety of patient information leaflets were available.

The SI said that he did not keep a record of blood test results for people taking higher-risk medicines such as methotrexate and warfarin. This could make it harder for the pharmacy to monitor people's previous blood test results. Prescriptions for higher-risk medicines and schedule 4 CDs were not highlighted. So, there is potential that the opportunity to speak with these people is missed. And there is more of a chance that these some items could be handed out when the prescription was no longer valid. The SI confirmed that team members checked CDs and fridge items with people when handing them out. He said that all patients taking valproate medicines were provided with warning cards and patient information leaflets when needed. There was currently one patient who needed to be on the Pregnancy Prevention Programme. The pharmacist said that he did not routinely provide the warning card when supplying these medicines to all people who may become pregnant. He said that he would ensure that these were supplied. The pharmacy had the warning cards and patient information leaflets available.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every month and this activity was recorded. Stock due to expire within the next three months was segregated and short-dated lists were kept for items due to expire within the next six months. There were no date-expired items found in with dispensing stock. Medicines were kept in appropriately labelled containers.

The trainee dispenser said that part-dispensed prescriptions were checked frequently throughout the day. 'Owings' notes were provided, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. The SI said that uncollected prescriptions were checked monthly. He confirmed that items uncollected after around three months were returned to dispensing stock where possible. Dispensed medicines waiting collection were not always accompanied by the prescription form. This could increase the chance of these being handed out when the prescription is no longer valid. The SI said that he would ensure that prescriptions were kept with the items until they were collected.

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 trainee dispenser said that people

requested these items when they needed them. 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. 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. Detailed medication descriptions were put on the compliance aids to help people identify their medicines. Patient information leaflets (PILs) were not routinely supplied. The trainee dispenser said that she would ensure that these were supplied in the future.

CDs were stored in accordance with legal requirements and 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.

Deliveries were made by a member of the team when needed. The pharmacy obtained people's signatures for deliveries where possible. The pharmacist said that a piece of paper was used to cover people's personal details. But this proved hard to do in practice. The pharmacist said that he would implement a more reliable way to record signatures while protecting people's information.

Licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist said that all team members were sent a copy of the email to ensure that they made aware if they were not working on the day it was received by the pharmacy. A detailed record was kept for all recalls and alerts and what action had been taken.

The pharmacy had the equipment installed in preparation for the implementation of the EU Falsified Medicines Directive. And team members had received training. The pharmacist said that he was in the process of writing an SOP for this.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy generally 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 not marked for cytotoxic use only. The trainee dispenser said that she would mark one. This would help avoid any cross-contamination.

The phone in the dispensary was portable so could be taken to a more private area where needed. The shredder was in good working order. 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.