General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hollis Pharmacy, 285 Upper Grosvenor Road, TUNBRIDGE WELLS, Kent, TN4 9EX

Pharmacy reference: 1033011

Type of pharmacy: Community

Date of inspection: 05/06/2019

Pharmacy context

The pharmacy is near a small parade of shops and a train station. It is surrounded by residential premises. And the nearest city centre is around two miles away. The people who use the pharmacy are mainly older people. It is an independent family run pharmacy part of a small chain. It offers a variety of services including Medicines Use Reviews and the New Medicine Service (NMS). And it provides multi-compartment compliance aids to around 30 people who live in their own homes and provides substance misuse medications to one person.

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 not all met	2.2	Standard not met	The pharmacy does not ensure that all team members are undergoing training appropriate for their role, in accordance with GPhC minimum training requirements.
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. The staff are not all fully aware of which tasks they can and cannot do if the pharmacist is not there. This could mean that tasks may be undertaken without suitable supervision. The pharmacy protects people's personal information. And it actively seeks feedback from people who use the pharmacy. It largely keeps the records it needs to by law.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. All standard operating procedures (SOPs) required by law were not available at the pharmacy. The missing ones included ‘the steps to be taken when there is a change of responsible pharmacist (RP) at the premises’. And ‘the arrangements which are to apply during the absence of the RP from the premises’. The missing SOPs may make it harder for the pharmacy team to know what the right procedures are. The pharmacist said that he would ensure that these were available. 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 not recorded. A near miss log was available but not used. The pharmacist said that he would ensure that this was used and reviewed for trends and 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 the issue had been resolved and the person’s prescription was changed because the items that were prescribed were not available.

There was limited workspace in the dispensary. An organised workflow 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 medicines counter assistant (MCA) thought that she could hand out bagged items and sell some pharmacy only medicines if the pharmacist was not in the pharmacy. Both trainee MCAs did not know that they should not sell general sales list medicines if the pharmacist had not turned up. The dispenser though that he could carry out dispensing tasks before the pharmacist turned up.

The pharmacy had current professional indemnity and public liability insurance in place. Records required for the safe provision of pharmacy services were generally completed correctly. All necessary information was recorded when a supply of an unlicensed special was made. The private prescription record and emergency supply record were completed.

Controlled drug (CD) running balances were checked around once a month. Liquid CD balances were checked every few months; 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. There were alterations made to the CD records. 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. The correct RP notice was clearly displayed. But the RP log had been completed a few days in advance to show who was going to be responsible on those days.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Smartcards 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. Some team members had completed General Data Protection Regulation training.

The pharmacy carried out yearly patient satisfaction surveys. And results were available on the NHS website. The pharmacy had a complaints procedure available for team members to follow when needed. The pharmacist said that a complaint had been received recently when a person was supplied with the wrong medicine. A note had been left by the regular pharmacist explaining that the medicine was out of stock at the suppliers, but this message had not been found by the pharmacist working on the Saturday and he had supplied the wrong item.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. The trainee MCA was unsure about all people who may be classed as vulnerable. She knew that children and older people may be vulnerable. The other trainee MCA did not know that she should 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 was not aware of any safeguarding concerns at the pharmacy.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough team members to provide its services safely. But not all of them are undergoing training appropriate for their role, in accordance with GPhC minimum training requirements. They can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets. Team members are not always provided with regular ongoing training. This could make it harder for them to keep their skills and knowledge up to date.

Inspector's evidence

There was one pharmacist, one part-time dispenser and two trainee MCAs working during the inspection. One of the trainee MCAs said that she had worked at the pharmacy for around 18 months. And this had included selling over the counter medicines. But she had not been enrolled on an accredited counter assistant course. The superintendent (SI) pharmacist enrolled her onto a course during the inspection. A second trainee MCA had not been enrolled on an accredited counter assistant course. The team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

The first trainee MCA appeared confident when speaking with people. She referred to the pharmacist to check whether she could sell more than one box of pseudoephedrine containing products. She confirmed would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. But she was not aware of most of these medicines or the reasons why. She knew some questions to ask to establish whether the medicines were suitable for the person. But she did not appear confident with all the questions.

The dispensers had completed the NVQ level 3 course in pharmacy services. The first trainee MCA said that she had received a training booklet from one of the suppliers. She said that she had completed it and the SI had marked it. But she had not undergone any training for several months.

The pharmacist said that the SI regularly visited the pharmacy to discuss any issues with the pharmacist. The dispenser said that he felt confident to discuss any issues with the pharmacist or SI as they arose. They appeared to have a good working relationship and discussed informally any tasks that needed to be done. The dispenser said that he had not had a performance review or an appraisal since he started working at the pharmacy around 17 years ago.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that he carried out the services for the benefit of the people using the pharmacy. He said that he did not feel under pressure to achieve the targets and he would not let his professional judgement be affected.

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. And this presented a professional image. Air-conditioning was available; the room temperature was suitable for storing medicines. There was one chair in the shop area. It had arms to aid standing. And it was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. Pharmacy only medicines were kept behind the counter or in glass cabinets next to the counter.

The consultation room was accessible to the side of the medicines counter. Low-level conversations in the consultation room could not be heard from the shop area. The window in the door was see-through. The pharmacist said that he used his jacket to cover the window when needed. He confirmed that he would look for a more permanent solution. There was a desk, sink and two seats available in the room. And the room was accessible to wheelchair users. 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 generally manages its services well. But it does not always highlight when high-risk medicines are dispensed, which may mean that people are not given all the information that they need to take their medicines safely. It gets its medicines from reputable suppliers. And it generally responds appropriately to drug alerts and product recalls.

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. A variety of patient information leaflets were available. Services and opening times were clearly advertised.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. He said that he kept a record of blood test results on the patient's medication record, but he could not show this during the inspection. Prescriptions for these medicines were not highlighted so there was potential that the opportunity to speak with these people was missed. Prescriptions for schedule 3 and 4 CDs were not highlighted. The trainee MCA was unsure how long these prescriptions were valid for. This could increase the chance of these being supplied when the prescription is no longer valid. The pharmacist said they checked CDs and fridge items with people when handing them out. He said that there were currently no patients who needed to be on the Pregnancy Prevention Programme. He said that the pharmacy supplied valproate medicines to a few patients. But it did not have the patient information leaflets or warning cards available. He confirmed that he would order replacements from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every two months and this activity was recorded. The dispenser said that stock due to expire within the next few months was marked or removed from dispensing stock. There were no short-dated items found with dispensing stock. But there were several mixed batches and tablets in dispensing bottles. The dispensing bottles were not correctly labelled and did not have batch numbers or expiry dates of the medicines recorded. This could make it harder for the pharmacy to respond to safety alerts or to date-check the medicines properly. The pharmacist said that he would remind team members to keep medicines in their original packaging.

The pharmacist said that part-dispensed prescriptions were checked regularly. 'Owings' notes were provided, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. There were only a few part-dispensed prescriptions at the pharmacy and these were dated within the last few months. The pharmacist said that uncollected prescriptions were checked around every two months. He said that items uncollected after this time were returned to dispensing stock where possible. There were prescriptions dated longer than two months ago and one dated six months ago which were waiting collection. The pharmacist said that he contacted people to ask if they still needed their medicines. Prescriptions were kept at the pharmacy until the items were collected.

The pharmacy did not order prescriptions on behalf of most people who received their medicines in multi-compartment compliance aids. Prescriptions for 'when required' medicines were not routinely requested by the pharmacy. The dispenser said that people usually ordered these when they needed them. The pharmacy kept a record for each patient which included any changes to their medication. 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. Medication descriptions were put on the compliance aids. And patient information leaflets (PILs) were routinely supplied to people.

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.

The pharmacy did not have the equipment for the implementation of the EU Falsified Medicines Directive. The pharmacist said that he did not think that this had been ordered. He confirmed that he would speak with the SI to find out if the pharmacy was due to receive the equipment.

Deliveries were made by a delivery driver. The pharmacy did not obtain people's signatures for deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. They carried out around 20 deliveries a day to people who needed that service.

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 these were actioned and kept for future reference. But there were several recent email alerts that had not been opened. The pharmacist said that he would ensure that these were actioned promptly upon receipt. And he would keep a record of any action taken.

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 marked for cytotoxic use only. This helped 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.