General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Osbon Pharmacy, 478 Old London Road, HASTINGS, East Sussex, TN35 5BG

Pharmacy reference: 1036230

Type of pharmacy: Community

Date of inspection: 24/10/2019

Pharmacy context

This is a community pharmacy in a parade of shops in Ore Village, on the outskirts of Hastings. It dispenses NHS prescriptions and people can ask to have their blood pressure checked. It offers sexual health services, seasonal flu vaccinations, Medicines Use Reviews and the New Medicine Service. It dispenses medication into multi-compartment compliance packs for people who live in their own homes and need help managing their medicines.

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	1.2	Good practice	The pharmacy is good at recording and reviewing any mistakes that happen during the dispensing process. This helps make the services safer for people to use.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	3.1	Good practice	The refit of the pharmacy has been done to a high standard. It has improved the available space, workflow, and the professional appearance of 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 identifies and manages the risks associated with its services to help provide them safely. It is good at recording and reviewing any mistakes that happen during the dispensing process. This helps make the services safer for people to use. Team members largely keep the records that they need to by law. And they know how to protect vulnerable people. The pharmacy generally protects people's personal information. But team members could do more to ensure that confidential waste is always disposed of appropriately.

Inspector's evidence

A range of standard operating procedures (SOPs) was in place, but not all of them had been signed by team members to indicate that they had read and understood them. Some team members were not familiar with all the SOPs relevant to their role, but they explained that they were in the process of going through them. One of the accuracy checking technicians (ACTs) said that she would encourage team members to go through the SOPs in the next few days.

Near misses were recorded as they occurred. Team members were made aware when a mistake had been made and they rectified it themselves. An ACT gave an example of a near miss that had occurred between the tablet and capsule forms of esomeprazole and showed that the different types had been separated on the shelf. White dispensing boxes were used in several places to separate different medicines, which helped keep the stock tidy. Team members showed how they separated medicines on the shelves that looked or sounded alike. The pharmacist said that he had talked with the staff about the different medicines used for Parkinson's disease, as some had very similar names and strengths. Near misses were reviewed each month as part of the NHS Quality Framework. The reviews were documented, and team members were involved in the discussion. They read and signed each review. Team members gave an example of a recent discussion they had had about a dispensing error involving insulin at one of these reviews where they talked about how they could prevent a repetition. They said that they now double-checked the insulin when it was taken from the fridge to ensure it was the correct type. Dispensing errors were recorded in the pharmacy and reported to the National Reporting and Learning System.

Team member's roles and responsibilities were defined in the SOPs, and a matrix was used to show which tasks each team member could do. The dispenser could describe what she could and couldn't do if the pharmacist had not turned up in the morning.

The pharmacy undertook an annual survey of the people who used the pharmacy and was in the process of doing the current one. The results from the previous survey were positive, with around 99% of respondents rating the pharmacy as very good or excellent overall. The complaints procedure was in the SOPs and team members explained how they dealt with any complaints that came in. A recent complaint had been passed on to head office and the superintendent pharmacist had written out to the person. The pharmacy had a 'mystery shopper' visit every quarter and the results from the previous two visits had been 83% and 100% overall.

The pharmacy had a current indemnity insurance certificate displayed. The responsible pharmacist (RP) log had largely been completed correctly, and the right RP notice was clearly displayed. Emergency

supply records and records for unlicensed medicines examined complied with requirements. Most private prescription records contained the required information, but a small number had the prescriber details missing. This could make it harder for the pharmacy to find these out if there was a future query. Controlled drug (CD) registers examined had been filled in correctly, and the CD running balances were checked regularly.

Confidential material was kept out of view of the people using the pharmacy. Confidential waste was usually shredded, but some labels were found in the general waste bin. Team members had used black marker pen to obscure people’s details, but on a small number of labels these could still be read. Team members said that they had been told not to shred the labels as they could gum up the shredder but said that they would find another way to destroy the labels properly. They had individual smartcards for accessing the NHS electronic systems and they had some awareness of the General Data Protection Regulation. The pharmacy had an information governance policy but staff had not signed it. They said that they would go through the policy to ensure that they were familiar with it. Computer terminal screens were turned away from people using the pharmacy and the terminals were password protected.

The pharmacy had a safeguarding policy but not all team members had signed it. However, they were able to describe what they would do if they had any concerns and contact details for local safeguarding agencies were available. The ACTs had completed the level 2 safeguarding training and the dispenser was going through the level 1 package. The pharmacist could explain what he would do if he had concerns about a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They communicate well together and manage their workload well. They undertake some ongoing training to help keep their knowledge and skills up to date. And they are able to raise concerns and make any suggestions to help improve the pharmacy's services. Team members can take professional decisions to help make sure that people get appropriate advice.

Inspector's evidence

At the time of the inspection there was one pharmacist, two ACTs, two trained dispensers, and a trained medicines counter assistant (MCA). In addition, the pharmacy employed another trained MCA, two trained dispensers who worked on Saturdays, and an untrained member of staff who had worked there for around a month. The ACTs could explain which prescriptions they were able to check but they had not been able to check many prescriptions recently because the pharmacy had been busy. They were aware of the need to keep their skills up to date and said that they did occasionally check prescriptions when they could. Team members were up-to-date with dispensing and the workload was well managed.

The pharmacist gave an example of a recent clinical decision he had made, where a person had been prescribed the 10mg strength of montelukast. This strength was out of stock, so he decided to offer double the dose of the 5mg strength and counselled the person accordingly.

Team members had meetings as and when issues came up, and they said that they had recently had a meeting about diabetes. They also regularly discussed any dispensing incidents when the reviews were done. Each staff member had an account for an online training system and they generally worked through training packages as they came out. But some team members were a few months behind on completing the ongoing training packages because of how busy the pharmacy had been. They said that it was often hard to get training time in work and they did the packages at home. This could make it harder for them to keep their knowledge and skills up to date.

Team members felt comfortable about raising any concerns and could make suggestions. And the registrants felt able to take any professional decisions as they came up. Targets were not set for staff.

Principle 3 - Premises ✔ Standards met

Summary findings

The refit of the pharmacy has been done to a high standard. It has improved the available space, workflow, and the professional appearance of the pharmacy. The premises are secure and people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy had received a refit around two years ago, and this had been done to a high standard. The amount of workspace had been increased, the lighting was better, and the design of the dispensary had helped make the workload clearer. The pharmacy projected a professional appearance to people who used it. The room temperature was suitable for the storage of medicines and was maintained with air conditioning.

The consultation room was clean and tidy. It allowed a conversation to take place inside which would not be overheard. There were some items inside which were not properly secured, but the room was locked when this was highlighted, and the pharmacist said that they would keep it locked when not in use. There were handwashing facilities available for staff.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. Team members dispense medicines into multi-compartment compliance packs safely. The pharmacy gets its medicines from reputable sources and stores them properly. It takes the right action in response to safety alerts to make sure that people get medicines and medical devices that are safe to use. The extended opening hours help people with a range of needs access the pharmacy's services. The pharmacy doesn't always highlight prescriptions for higher-risk medicines, and this could mean that opportunities to speak with people collecting these medicines may be missed.

Inspector's evidence

There was step-free access to the pharmacy from outside, and a list of services was displayed in the window. The pharmacy had wide aisles which made it easier for people with wheelchairs or pushchairs to manoeuvre. Team members explained how they put stickers on people's medication bags to make them aware that the pharmacy offered flu vaccinations. They said that the opening times had been extended to 7pm in the evening to make it easier for people to access the services. And they said that they had received good feedback from people since the change had been made, as people valued being able to pick up their prescriptions after work.

Baskets were used during the dispensing process to prevent people's medicines becoming mixed up, and there was a clear workflow through the pharmacy. A designated area was used to prepare multi-compartment compliance packs. The packs were labelled with a description of the medicines, and an audit trail to show who had checked and dispensed the pack. Team members explained that if people were unable to get their medicines out of the plastic packs they supplied disposable cardboard packs instead. Medicines which needed to be taken when required were not routinely included in the packs, and one of the ACTs said that they contacted people each month to see if they needed them. The list of people using the packs was split over four weeks to help manage the workload; the list also included people who did not use the packs but may forget to take their medicines. Team members contacted these people who needed additional assistance to help make sure they got their medicines on time. Any changes in medicines or communication with the prescriber were documented on the electronic patient medication record (PMR). The ACTs and dispenser dispensed the compliance packs so that there were other team members available if one was away from work. People were assessed by the regular pharmacist before they were started on the packs, and they spoke with the person's surgery or carers as appropriate. Team members said that they sometimes asked people how they were getting on with their trays when they spoke with them on the phone.

Prescriptions for higher-risk medicines such as warfarin or methotrexate were not routinely highlighted. So, opportunities to speak with people collecting these medicines may be missed. The pharmacist said that they would highlight these prescriptions in the future. The pharmacist was aware of the guidance about pregnancy prevention to be provided to people in the at-risk group who took valproate. He was not aware of any people in the at-risk group. The pharmacy had the associated cards and leaflets, but had run out of stickers; the pharmacist said that he would order more in.

Prescriptions for CDs were not routinely highlighted, and this could make it harder to check if the prescription was still valid when the medicines were handed out. A bag of dispensed medicines

containing diazepam (a Schedule 4 CD) was found on the shelf and it had expired; this was immediately removed. Team members said that they would highlight CD prescriptions in the future. The prescriptions were retained with dispensed medicines so that it was easier to check any details if there was a query.

If the pharmacy could only provide part of a supply to a person, they provided them with an ‘owings’ note. Team members explained how they went through the owings each day and contacted the manufacturer if there was a long-term problem. Prescriptions were retained with owings, which helped to reduce the chance of a mistake being made when it was dispensed. The pharmacy had the equipment it needed to comply with the Falsified Medicines Directive, including scanners and relevant SOPs. Team members had started using the equipment to decommission medicines but said that not many of the medicines that came in had the 2D barcode on them.

An audit trail was used when deliveries of medicines to people’s homes were made. Recipients signed to indicate safe receipt, and the signatures were collected on separate pages to help protect people’s personal information. Signed in-date patient group directions were available in the pharmacy for the relevant services provided.

Medicines were obtained from licenced wholesale dealers and specials suppliers. A date-checking routine was used, and checks were recorded. No date-expired medicines were found on the shelves sampled. The medicines were stored in an orderly manner and different strengths of medicines were well separated. Bulk liquids were marked with the date of opening so that team members knew if they were still suitable to use. CDs were stored securely. Medicines for destruction were separated from stock and kept in designated destruction bins and sacks. The team members explained how they dealt with drug alerts and recalls as they came in. A record was made of the action that had been taken as a result.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

A range of calibrated glass measures was available, with separate ones used to measure liquid methadone. Tablet counting triangles were clean, and a separate marked triangle was used to count methotrexate. The use of separate marked equipment helped avoid cross-contamination.

The blood pressure meter did not have a date recorded of when it had last been recalibrated or replaced, but the pharmacist said that it was less than two years old. Adrenaline pens were available for when vaccinations were done. The phone was cordless and could be moved to somewhere more private to help protect people’s personal information. And the fax machine was away from the public area. Team members had access to up-to-date reference sources including the internet.

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.