General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hampton Pharmacy, Hampton Pharmacy & Opticians, 14 Stewartby Avenue, Hampton Vale, Peterborough, Cambridgeshire, PE7 8NJ

Pharmacy reference: 1099365

Type of pharmacy: Community

Date of inspection: 17/12/2019

Pharmacy context

This community pharmacy is situated amongst several other retail and food outlets which cater for a relatively new housing development on the outskirts of Peterborough. Most of this pharmacy's activity centres on dispensing NHS prescriptions, some of which it delivers to people's homes. It also provides seasonal flu vaccinations, blood pressure checks, and its staff provide advice and sell medicines over the counter. The pharmacy supplies some people who need help managing their medicines with multi-compartment compartment compliance packs. The superintendent pharmacist (SI) works full-time at this pharmacy.

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	1.8	Good practice	The pharmacy team members have all completed safeguarding training. And the pharmacy can show how it has taken the right action to protect a vulnerable person.
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's team members generally follow safe practices. They understand what they can and cannot do when there is no pharmacist present. The pharmacy team members understand their role in protecting vulnerable people and escalate concerns so that people can get the care and support they need. They know how to keep people's private information safe. And they make improvements when things go wrong. But they don't always keep a record of why some mistakes have happened. So, they may find it harder to spot any patterns in mistakes and take the right action to stop these happening again.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs). The SI reviewed the SOPs periodically to make sure they reflected the pharmacy's activities. The procedures covered dispensing activities, management of controlled drugs (CDs), over-the-counter medicines sales, safeguarding vulnerable people, the pharmacy delivery service, and supplying medicines in multi-compartment compliance packs. There were also written procedures about protecting people's information and dealing with dispensing errors or other adverse incidents. Pharmacy staff had read SOPs relevant to their roles and signed the documents to show they had done so. Some locum pharmacists who worked at the pharmacy regularly had not signed the SOPs.

There was a process to record, report and review any dispensing errors which had reached patients. Following a recent incident where the wrong amount of a CD had been dispensed, more regular balance checks had been started to help prevent a similar occurrence in future. A root cause analysis had been undertaken, the pharmacist involved in the error informed, and the matter had been reported correctly to the CD Accountable Officer. There was also a process to record those mistakes, referred to as near misses, which were spotted and corrected during the dispensing process. The dispensers were encouraged to identify and rectify their own mistakes so they could learn from these. Near misses were recorded regularly, though the records contained little information about possible reasons for why the mistakes had been made. And improvement actions against individual events tended to be non-specific. The records were reviewed periodically and there was some evidence that learning points from these reviews were shared with the team. Some medicines with similar sounding names, similar packs, or with multiple strengths had been more clearly separated on shelves to prevent selection errors. For example, modified-release and standard-release tramadol were kept on separate dispensary shelves. And a 'check strength' sticker had been applied to the storage location for amitriptyline.

The pharmacy's services were appropriately insured. To help manage the risks associated with some medicines, there were alert stickers to highlight when additional care was needed when prescriptions for these items were handed out. When asked, staff had some understanding about the questions to ask people taking methotrexate or warfarin when these medicines were handed out. But prescriptions for these items were not always flagged. This could make it harder for the pharmacy to be sure that people always receive the advice they need to take their medicines safely.

Members of the public could readily identify members of the pharmacy team; the staff wore uniforms and name badges showing what their roles were. When asked, the team members could confidently

explain what they could and couldn't do in the absence of a responsible pharmacist (RP). Prescription labels, including those on compliance packs, were initialled at the dispensing and checking stages. This meant the pharmacy could be sure who had completed each of these tasks. Team members were observed asking people questions before selling medicines to establish if it was safe to proceed with a sale. They could explain which medicines were more closely controlled to minimise the risk of misuse, for example, pseudoephedrine-containing medicines and codeine-containing painkillers. And the staff referred queries to the pharmacist throughout the visit.

The pharmacy sought feedback from people about its services using an annual survey. Results from the most recent survey were displayed in the pharmacy and were largely positive. There was a complaints procedure which enabled people to raise concerns about the pharmacy and staff would refer people to the pharmacist if needed. There was some information displayed in the pharmacy about how to make comments or complaints.

The RP notice showed who the pharmacist in charge was and it was displayed where the public could see it. The RP record was largely complete and provided information about who had been the pharmacist in charge of the pharmacy. Records about Schedule 2 CDs were largely complete and running balances were kept and checked regularly. Some of the writing in the register was virtually illegible; the pharmacist had already been made aware of this by members of staff. Patient-returned CDs were recorded when received; all previous returned CDs had been destroyed and there were denaturing kits available. Private prescriptions and emergency supplies were recorded in a book. Private prescription records did not always include all the required information about the prescriber. The pharmacist agreed to make sure these were recorded fully in future. Records about the supply of unlicensed specials were complete.

To protect people's confidentiality, waste containing sensitive information was segregated and disposed of by specialist waste contractors. Information governance arrangements were audited. Staff had read and signed the written procedures about information governance. And there were confidentiality clauses in the team members' contracts. A privacy notice was displayed, telling people how their information was used. Patient medication records were password protected and could not be viewed from the shop floor. And staff used their own NHS smartcards to access electronic prescriptions and kept their passwords private.

There were procedures to help make sure the pharmacy took appropriate action to protect vulnerable people. There was a chaperone policy for use of the consultation room. The pharmacist had completed level 2 safeguarding training, and staff had also completed safeguarding training relevant to their roles. Details about local safeguarding procedures and contact information for local safeguarding agencies was readily available. The team members were able to give an example of reacting appropriately to concerns about a vulnerable person so that they got the help they needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are suitably trained for the roles they undertake. They can share ideas to improve how the pharmacy operates. And they can raise concerns if needed. They receive some support in keeping their skills and knowledge up to date. There are opportunities for the team to be more involved in learning from events such as near misses.

Inspector's evidence

The pharmacy's staff comprised the responsible pharmacist (the SI), three part-time dispensers, one full-time dispenser, and a delivery driver. Each of the dispensers had undertaken an accredited training course which had covered dispensing activities and selling medicines over the counter. Training certificates showing that staff had completed this training were displayed at the counter. Some of the staff had completed additional training to enable them to offer support for Stop Smoking and Healthy Living services. Staff were sometimes able to do training at work during quieter periods. The SI provided some ongoing coaching to his staff. Current topics had been about the links between prescription medicines and over-the-counter items, increasing the team's understanding of the effects of different medicines, and dose calculations for some prescriptions. Team meetings were held on a monthly basis and evidence of these was kept. The staff said they also had more informal discussions as a team each week.

The team were able to cope with their workload during the inspection. They answered the phone promptly and acknowledged people when they came into the pharmacy. When asked, the dispensers were able to describe the types of questions they asked before selling medicines, to make sure the medicines were appropriate for people to take. They knew which medicines could be misused and when they needed to refer requests to the pharmacist. They also understood what they could and couldn't do when there was no pharmacist present.

The team members worked closely together and were seen to discuss queries with each other throughout the visit. The staff said they could make suggestions about how to improve the pharmacy's activities and would feel able to raise any concerns or provide feedback to the SI or other responsible pharmacists. One of the team mentioned they had already fed back to one regular pharmacist about their handwriting which was very difficult to read and made it harder for other people to understand. The SI had a network of pharmacists he could contact for support and advice. He said that they had targets for some services, but these did not impact on his ability to exercise his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are safe and appropriate for the services it provides. They can be protected against unauthorised access.

Inspector's evidence

The premises were bright and clean and generally presented a professional image to members of the public. There were some maintenance contracts in place and a cleaner visited once a week. The room temperature was appropriate for storing medicines. And there was good lighting for dispensing activities. The entrance door was wide enough to accommodate wheelchairs and prams and there was level access into the shop from the street.

The dispensary was clearly separated from the retail area and was not readily accessible to people visiting the pharmacy. But the pharmacist and staff had good visibility from the dispensary of anyone who needed help at the counter. Prescriptions waiting collection were stored in a designated area away from the counter meaning that medicines and people's information was protected. Pharmacy-only medicines were stored behind the counter to prevent self-selection. Medicines for dispensing were stored off the floor. There was ample dispensing bench space for the workload and sections of bench space were reserved for specific tasks such as preparing multi-compartment compliance packs. This was to reduce the risk of mistakes happening.

There was a spacious, well-screened consultation room, set to the side of the medicines counter. This room was signposted and was used during the visit for providing services which needed greater privacy. Details of the pharmacy's chaperone policy were displayed for people using the room. There was seating, a table, and lockable storage space in the room. Most surfaces were clean though the seat covering on one chair was slightly ripped and stained. The SI said he would replace this.

Staff had a separate area for storing food stuffs and making drinks. The hygiene facilities were clean and there was hot and cold running water at most of the sinks. Hand sanitisers were available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's services are undertaken safely and effectively. It gets consent from people for the services it provides to them. It takes the right action in response to medicine recalls and safety alerts to protect people's health and well-being. And it gets its medicines from reputable sources and generally stores them and other stock safely. The pharmacy team members dispense prescriptions in an organised way. But they don't always supply the package leaflets that come with medicines to people. So, some people may not have all the information they need about their medicines. And there are opportunities for the pharmacy to review the delivery service to make sure it assesses and manages all risks fully.

Inspector's evidence

There was some information displayed in the pharmacy about the services it provided and its opening hours. But the pharmacy did not have its practice leaflet available. So, some people may not have known about all the services the pharmacy could provide. Staff had created a display giving information to people about asthma. There was also information available about other healthcare matters and services offered by other agencies.

Dispensing was undertaken in an organised manner. Baskets were used to separate prescriptions and prioritise the workload. There was an audit trail on all dispensed items showing who had dispensed and checked the medicines. Prescription forms were kept with dispensed medicines so could be referred to when people came to collect their medicines.

Medicines were supplied to some people in multi-compartment compliance packs when people needed this level of support. The packs were prepared in a designated area of the dispensary. Prescriptions were ordered on behalf of people and missing items or unexpected changes were queried with the person or their GP. The dispenser explained that she waited for all items to be prescribed and received before assembling the packs. Records of any interventions or changes were generally made on people's records. The packs were labelled with the dose and any warnings. Tablet descriptions were sometimes added when these were requested. Package information leaflets were not always given to people. The SI agreed to make sure this was done in future. The dispenser could explain the types of medicines they generally wouldn't put in the compliance packs, for example, medicines with varying doses or medicines which were hygroscopic. There was a process to retrieve and reissue new packs if changes were made to people's medication mid-cycle.

The pharmacist was aware of the need to provide information about pregnancy prevention to people in the at-risk group who were supplied valproate-containing medicines. The pharmacy had warning stickers to apply to dispensed medicines and patient safety literature to hand out to people. The pharmacy made checks to make sure that people taking warfarin were being monitored appropriately. These checks were not generally recorded, and the SOP was not clear about what should happen. The SI said he would review the process.

The pharmacist had completed the necessary training to safely provide the seasonal flu vaccination service under a patient group direction. The consultation room was suitable for this service and the

pharmacy had the right equipment available. There was a SOP covering what to do in the event of a needlestick injury. Sharps waste was stored safely. There was evidence of the pharmacy obtaining consent and confirming that exclusion criteria did not apply to people attending for this service before administering vaccinations. Due to recent supply problems with adrenaline auto-injectors required in the event of an anaphylaxis reaction, the service had been put on hold pending further supplies being obtained.

The delivery driver kept a record of the prescriptions he delivered. He sometimes got signatures from the people when he had delivered their medicines. He sometimes posted small packs of medicines through letterboxes if the person wasn't at home. This activity was not always accompanied by a formal risk assessment or with the agreement or knowledge of the SI. The SI said he would review the current process to make sure risks such as the presence of pets or young children were fully considered and mitigated.

The pharmacy got its medicines from licensed wholesalers and specials were obtained from specials manufacturers. No extemporaneous dispensing was carried out. Medicine stock for dispensing was stored in an orderly fashion, out of reach of the public. CDs were stored securely. There was a process to date-check stock regularly and this activity was recorded. Short-dated stocks were highlighted to reduce the risk of supply beyond the expiry date. Dates of opening were applied to most liquids which had reduced shelf-lives once opened. However, one stock container had not been marked when opened. No out-of-date medicines were found when stock was spot-checked. One pack contained two different brands of medicine. The pharmacy manager was advised this could make date-checking less effective and to keep all medicines in appropriately labelled containers. Out-of-date medicines and patient-returned medicines were transferred to designated bins and these were stored away from dispensing stock. There was a reference sheet so staff could identify hazardous waste but there was no separate bin for disposing of cytotoxic medicines. The SI said he would investigate this with the waste contractors.

The SI explained how the pharmacy had been trying to manage supply issues affecting hormone replacement therapies. This had involved contacting suppliers regularly for updates, keeping local GPs informed and advising people to return to their prescriber for an alternative if necessary.

The pharmacy had the equipment it needed to comply with the Falsified Medicines Directive (FMD). The equipment was in use, but staff said many medicines did not have the applicable barcodes. Appropriate arrangements were in place for storing CDs. There was enough storage capacity for medicines requiring refrigeration. The medicines fridge was equipped with a maximum and minimum thermometer and temperatures were checked daily and recorded. The records seen were within the appropriate range. The pharmacy had a process to receive drug recalls and safety alerts direct from the MHRA and other sources. The pharmacy provided evidence of how it had received and acted on recent alerts including for ranitidine products.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment and facilities it needs for its services. It uses up-to-date information sources when providing advice or when making clinical checks. And it keeps people's personal information safe.

Inspector's evidence

The pharmacy's measuring equipment was largely of an appropriate standard. It had a small number of crown-stamped measures for liquids, but it relied on plastic syringes for measuring small volumes. The SI said he would order an appropriate measure to avoid this in future. There were two counting triangles for tablets. One was reserved for cytotoxic medication to prevent cross-contamination of other tablets. Both triangles had dust residue on the surface; these were cleaned as soon as this was pointed out. Electrical equipment appeared to be in good condition. There was no process to test this equipment periodically. The SI said he would review this.

To help make sure advice to people and clinical checks were based on current information, the pharmacy had access to up-to-date reference sources in hard copy and online. The team members used cordless handsets for phone calls so could hold conversations out of earshot of people waiting in the shop. Personal information held on equipment in the pharmacy was stored out of sight and reach of the public. The pharmacy had a hearing induction loop at the front counter to help people who used hearing aids.

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.