General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hopton Pharmacy, 1 Warren Road, Hopton-On-Sea, GREAT YARMOUTH, Norfolk, NR31 9BN

Pharmacy reference: 1120885

Type of pharmacy: Community

Date of inspection: 17/02/2020

Pharmacy context

The pharmacy is located near to a large holiday park in a largely residential area. The people who use the pharmacy are mainly older people. And the pharmacy sees an increase in over-the-counter supplies of medicines and emergency supplies in the warmer months. The pharmacy receives around 90% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service and influenza vaccinations. It also supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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	1.2	Good practice	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk.
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 identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information and it regularly seeks feedback from people who use the pharmacy. Team members understand their role in protecting vulnerable people. The pharmacy largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its 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 identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The different strengths of amitriptyline and naproxen had been moved to different shelves to help minimise the chance of the wrong medicine being selected. The pharmacy now dispensed insulin when the person presented to collect their medicines and these were not put in the bag until they had been shown to the person. The outcomes from the reviews were discussed openly during the regular team meetings. Dispensing incidents where the product had been supplied to a person were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where some insulin pens were dispensed instead of cartridges. The locum pharmacist had dispensed and checked the items themselves and there had not been a second check by another member of the team. The superintendent (SI) pharmacist explained that this was not usual practice at the pharmacy and team members were seen asking for second checks of their dispensing during the inspection.

Workspace in the dispensary was 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 she would attempt to contact the SI if a pharmacist had not turned up in the morning. She thought that she could sell general sales list medicines and carry out dispensing tasks before there was a responsible pharmacist (RP) signed in. But she knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. The inspector reminded the team members about what they could and couldn't do if the pharmacist had not turned up. There was a matrix displayed in the dispensary showing which tasks should not be carried out in the absence of the pharmacist. Team members could refer to this if needed.

The pharmacy had current professional indemnity and public liability insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. There were signed in-date Patient Group Directions available for the influenza vaccination service. Controlled drug (CD) registers examined were filled in correctly and the CD running balances were checked at regular

intervals. Liquid overage was recorded in the register. And the recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were largely completed correctly, but the prescriber's details and the date on the prescription were not always recorded correctly. This could make it harder for the pharmacy to find 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. The SI said that he would ensure that the private prescription record and emergency supply record had all the relevant details on in the future. The responsible pharmacist (RP) log was largely completed correctly and the right RP notice was clearly displayed. But the SI had completed the log before he had finished his shift.

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 and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. Some team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2019 survey were available on the NHS website. Nearly all of the respondents were satisfied with the service they had received. The complaints procedure was available for team members to follow if needed. The SI said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The SI 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 team members to provide its services safely. They do the right training for their roles and they discuss adverse incidents and use these to learn and improve. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions. This means that they can help improve the systems in the pharmacy. 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 was one pharmacist and three trainee dispensers working during the inspection. Two of the dispensers had been enrolled on a dispenser course and the other had worked at the pharmacy for around one week. The SI said that all team members would be enrolled on a suitable course for their role within the required timeframe. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee dispensers appeared confident when speaking with people. One, when asked, said that she would refer to the pharmacist if a person asked to purchase more than one box of a medicine. 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. She knew the appropriate questions and used these to establish whether the medicines were suitable for the person.

The SI was patient when training the trainee dispensers. He explained to one of them to check the dispensing label against the prescription and the medicine against the prescription. He told her not to select the medicine using the dispensing label as a reference and to use the prescription instead. He explained that calcium-based products and insulins are easy to incorrectly select. And he talked about the difference between the generic name and the brand name of products. The trainee dispenser was told during the inspection to ensure that any packaging remained with the prescription and medicines throughout the dispensing and checking processes. Team members had had regular reviews of any dispensing mistakes and discussed these openly in the team. And they were encouraged to record their own mistakes.

The SI was aware of the continuing professional development requirement for the professional revalidation process. He said that he kept his knowledge up-to-date by reading pharmacy related magazines. And he had recently read some information about sepsis. He said that he felt confident to take professional decisions. And he had completed declarations of competence and consultation skills for the influenza vaccination service, as well as associated training.

Team members said that they felt comfortable about discussing any issues with the SI as they arose. They referred to him throughout the inspection when they were unsure about anything. The SI said that he planned to have quarterly staff meetings but it was not always possible to get everyone to attend due to people's shifts. He said that any issues were discussed at the time and a record was kept of any important communications so that other team members could refer to this where needed.

Targets were set for Medicines Use Reviews and the New Medicine Service. The SI said that these

services were provided for the benefit of the people who used the pharmacy and his professional judgement was not affected by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available; the room temperature was suitable for storing medicines.

There were two 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. The consultation room was accessible to wheelchair users and was located to the side of the medicines counter. It was suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area.

Toilet facilities were clean and there were hand washing facilities in the dispensary. The toilet area was large and it was used to store some waste medicines and empty multi-compartment compliance packs. And this made it harder for the pharmacy to show that these medicines were being kept securely. The SI said that work had started to move the toilet area and then the room it was currently in could be used to store pharmacy items.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. It dispenses medicines into multi-compartment compliance packs safely. People with a range of needs can access the pharmacy's services. 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 a small step up to the pharmacy. 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.

The SI said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The SI said that he had started to highlight prescriptions for Schedule 3 and 4 CDs. But there was one found in the retrieval system which was no longer valid and it was not marked. The SI said that he would ensure that they were marked in the future to help minimise the chance of them being handed out when the prescription was no longer valid. The SI explained that fridge items were dispensed when the person came to collect their medicines. He said that these and CDs were checked with people when handing them out. The SI said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information leaflets available, but it did not have additional warning cards. Most of the medicine boxes had the warning cards attached and the SI said that he would order replacements from the manufacturer.

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 six months was marked. There were no date-expired items found in with dispensing stock and medicines were largely kept in their original packaging. Some medicines were kept in white dispensing boxes and it was not clear whether these were all from the same batch. The SI placed the ones with no details on in the pharmaceutical waste container. He said that he would ensure that the part of the foil strip with the batch number and expiry date was kept in the future, so that this information could be recorded on the container.

Part-dispensed prescriptions were checked frequently. '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 kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked every few months. The SI said that uncollected prescriptions were returned to the NHS

electronic system or kept at the pharmacy until they were no longer valid. And the items were returned to dispensing stock where possible.

The SI said that people had assessments carried out by their GPs or the medicines optimisation team to show that they needed their medicines in multi-compartment compliance packs. 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 SI said that people contacted the pharmacy if they needed them when their packs were due. The SI said that items were checked against the prescription before being dispensed into the packs. And then the packs was checked again before being sealed. They then received a third and final check by the pharmacist. 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 some deliveries and these were recorded in a way so that another person's information was protected. But it did not obtain signatures for all deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. The SI said that he would speak with the driver and ensure that signatures were recorded for all deliveries where possible. When the person was not at home, the items were 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. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. 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 did not yet have the equipment to be able to comply with the EU Falsified Medicines Directive. The SI explained that he had received the authorisation code and was in discussions with the software provider about having the equipment installed.

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 but not for volumes less than five millilitres. A separate liquid measure was 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 SI said that the blood pressure monitor had been in use for around a year. 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.