General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hassengate Pharmacy, Hassengate Medical Centre, Southend Road, STANFORD-LE-HOPE, Essex, SS17 0PH

Pharmacy reference: 1124245

Type of pharmacy: Community

Date of inspection: 05/04/2019

Pharmacy context

This is a busy community pharmacy attached to a medical centre. The pharmacy sells a range of over-the-counter medicines and dispenses NHS prescriptions. The pharmacy stays open for 100 hours a week, opening early in the morning and closing late in the evening. It offers a range of services including travel vaccinations.

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	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's working practices are safe and effective. The pharmacy manages risks well and keeps people's private information safe. It generally keeps the records it is required to by law. But it does not always record the full details for some of the records. This may make it harder to find full details of what had happened if there was an issue. The pharmacy asks its customers and staff for their views. Team members use the procedures in place to safeguard vulnerable people.

Inspector's evidence

Standard Operating Procedures (SOPs) were in place and were up to date; some SOPs were due to be reviewed later this year. Members of the team had read SOPs relevant to their roles. Team roles were defined within the SOPs using a colour coded system; however, as these had been printed in black and white it was not always clear. The superintendent pharmacist (SI) assured that she would consider printing the SOPs in colour when she carried out the next review.

Near misses were brought to the attention of the team member who had made the mistake; they were asked to rectify the error and make a record on the near miss log. Near misses were observed to be consistently recorded but the contributory factors were not always recorded; although they were said to be discussed at the time. Near misses were reviewed monthly by the responsible pharmacist (RP) and a patient safety report was completed. Findings from this review were then shared with the team at the monthly meeting. As well as any actions that could be taken to avoid reoccurrence and how the ways of working could be changed. The second pharmacist came in earlier to attend the meeting. As part of one of the meetings the RP had discussed look alike sound alike drugs with the team. She had sourced reading material from the PSNC website and asked the team to read and sign the document. Following the briefing amlodipine and amitriptyline were moved on the shelves to ensure picking errors did not occur. The RP said that she also completed risk assessments to see how she could avoid errors from occurring.

All reported dispensing incidents were recorded on an incident report form with a copy sent to head office. The pharmacy was part of the Allcures group. A report was also submitted on the National Reporting and Learning System.

Prompts had been attached near the shelves to remind team members to check the name, strength etc when picking stock.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP.

Professional Indemnity insurance was in place with Numark, expiring on 30 September 2019.

The pharmacy had a complaints procedure in place. Details of which were listed in the information leaflets. The pharmacy also completed annual patient satisfaction surveys and had obtained approximately 87% positive feedback in the last survey completed. People using the pharmacy were usually happy with the services provided. There had been some feedback that some people had wanted more advice on physical exercise; as a result of this the RP had included details of local walks as part of the healthy living campaigns. Some people had also wanted smoking cessation services to be provided;

however, these were not commissioned by the local clinical commissioning group. The team including the RP counselled people on smoking cessation and the RP also included this as part of the MUR.

Records for private prescriptions, unlicensed specials, RP records and controlled drug (CD) registers were well maintained. Emergency supply records were generally well maintained but the reason for supply was not always included for all supplies including those carried out under the NHS Urgent Medicine Supply Advanced Service (NUMSAS).

CD balance checks were carried out on a weekly basis.

A random check of a controlled drug complied with the balance recorded in the register.

CD patient returns were recorded in a register as they were received.

Assembled prescriptions were stored away from the view of people. An information governance policy was in place. When the General Data Protection Regulation had come into place the RP had briefed the team and discussed how it would affect them and all team members had been asked to read an information sheet. Team members had also read SOPs on confidentiality. Team members had their own smartcards. Summary care records could be accessed by the pharmacists and consent was gained verbally and annotated on the patient medication record (PMR).

The RP and other pharmacists who worked at the pharmacy had completed safeguarding level two training. The accuracy checking tecnician (ACT) had completed a level one course. Details for the local safeguarding contacts were available. The RP had briefed the team on safeguarding procedures and had asked colleagues to notify the RP if they had suspicions. A child protection information leaflet was attached to the wall in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided. They have the appropriate skills, qualifications and training, and they are supported when doing ongoing learning. This helps them to deliver the services safely and effectively.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the RP, an accuracy checking technician (ACT), a counter assistant and two dispensers. The RP was also the superintendent pharmacist and worked at the pharmacy regularly.

The RP said that there were enough staff for the services provided. Holidays and absences were covered within the team. At any given time, there were always two additional team members with the RP.

Staff performance was managed by the RP who carried out individual reviews with the team annually. As part of the review the team member and RP looked at what the individual had done so far and agreed what they needed to achieve in the next 6 months.

Team members had been enrolled on the Numark online training service. As part of this counter excellence modules were completed each month. The last module which the team had completed was on travel health to coincide with the summer season. The RP could view a dashboard which showed her what training had been completed by everyone. The team were provided with study time during the evening or when they had free time to complete the modules or they could do them at home.

One of the team members was completing an apprenticeship. The apprentice attended college one day a week and an assessor from the college visited the pharmacy every 12 weeks to see how the apprentice was progressing. The RP was able to contact the assessor via email and give them feedback on the apprentice's progress in the pharmacy during the reviews. The RP brought to attention any gaps in knowledge or areas that team members needed to focus on.

Meetings were held on a monthly basis with briefings held in between if anything new came up. The RP said that a briefing had been held to discuss the change in schedule of pregabalin and gabapentin. The whole team had been included in this as it was of relevance to everyone. The team also used a communication diary to leave messages for colleagues working on different shifts.

Communication was received from head office via email. The RP felt that she was able to give feedback and suggestions to the owners. A discussion was held on services offered and how things were done. Next steps were decided in mutual agreement.

Targets were in place for services such as MURs, with the pharmacy expected to complete 400 consultations per year. The RP said that as the pharmacy was busy and had extended opening hours there were no issues with meeting the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services.

Inspector's evidence

The pharmacy was clean and well maintained. There was ample workbench space available which was kept clear and free from clutter to minimise the risk of dispensing incidents occurring. Workspace was also allocated for certain tasks and a designated area was used to manage the compliance aid service. Cleaning was done by the team. A sink was available in the dispensary for the preparation of medicines. Medicines were arranged on shelves in a tidy and organised manner. There were some large assembled prescription bags stored on the floor in the dispensary. The RP assured that these would be moved.

There was a large consultation room available which was clean, tidy and well-organised. The room could be accessed from the shop floor and the dispensary. The consultation room was kept locked when not in use. There was some patient confidential information stored in folders on shelves in the room; the RP said that people were not left unattended.

The premises were kept secure from unauthorised access

The room temperature and lighting were adequate for the provision of healthcare. Air conditioning was available to help regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are generally delivered in a safe and effective manner. The pharmacy obtains medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use. It does not always give people information leaflets that come with their medicines and does not securely attach backing sheets to people's compliance aids. It does not use some of the safety materials (such as warning stickers) for the supply of valproate. This means that people may not always have the information they need to take their medicines safely.

Inspector's evidence

The pharmacy was easily accessible from the car park. There were power assisted doors and there was easy access to the medicines counter. The team would assist people who needed help. The pharmacy could produce large print labels if needed. Pharmacy services available were advertised. There were a number of chairs for people wanting to wait. The responsible pharmacist (RP) was multilingual but most people using the pharmacy spoke English.

The pharmacy team routinely signposted patients to other local services. Most of the team members lived locally and were familiar with local services or team members used the internet to find this information. The local area had hub clinics around the area where the RP was able to refer people if she felt that they needed to see a GP. People did not need to be registered with the hub clinic to access the services.

The RP said that the NMS had the most impact on the local population. She said that people were able to ask questions about how their medicines worked or side-effects as well as any concerns that they had. The RP said that through the service people could gain reassurance and she would refer to the GP where appropriate. The RP gave an example of someone who had been prescribed new diabetic medication and at the first intervention meeting had discussed side-effects that they had been experiencing. The RP had been able to assure them that it was common side-effect and should wear off after some time and that if they were still concerned to return to the pharmacy after a week. The person had been reassured as they had been unable to get an appointment with the diabetic nurse for another month.

The pharmacy was a Healthy Living Pharmacy and ran promotions to help the local population improve their health and wellbeing. At the time of the inspection the pharmacy was running a diabetes prevention week. As part of this the RP had included information of local walking groups to encourage people to exercise and make lifestyle changes.

The pharmacy had an established workflow in place. Designated baskets were used for walk in prescriptions to help manage the workflow. A designated workbench was also used for dispensing walk in prescriptions. Prescriptions were usually dispensed by the dispensers and checked by the RP. On some rare occasions the pharmacist self-checked; to reduce the risk associated with this she took a mental break in between dispensing and checking.

Dispensed and checked by boxes were initialled to help maintain an audit trail. The pharmacy team also used colour coded baskets to ensure that people's prescriptions were separated, to reduce the risk of errors and to help manage the workflow.

The ACT only checked compliance aids for stable patients; there was no process in place to indicate which prescriptions could be checked by the ACT. This could result in the ACT checking prescriptions which had not been clinically checked by a pharmacist.

The team were aware of the need for monitoring when people were taking certain high-risk medicines such as warfarin. The team checked the yellow book and recorded the INR. For people taking methotrexate and lithium, they checked that the patient had their bloods tested and made them aware of the signs of toxicity.

The pharmacy also offered a warfarin service. After going to the anticoagulant clinic and getting their INR tested, people presented to the pharmacy with their yellow book. The RP checked INR results, the date that they had their test, the date of the next test and the strength and number of tablets they needed to take. This service could only be used by those who were stable and if their INR was within the required range. People who fell out of the range were referred back to the anticoagulant clinic.

The RP had an awareness of the change in guidance for dispensing sodium valproate. The RP said that the pharmacy which she had been working at previously had received the 'Prevent Pack'. She confirmed after the inspection that she had found the pack at the pharmacy. The pharmacy had not completed any audits on the use of sodium valproate. The team were unfamiliar with the requirement to use the warning sticker if sodium valproate was not dispensed in its original pack.

Prescriptions for controlled drugs (CD) were annotated with stickers. This was done for all schedules of CD including schedule 3 and 4 including pregabalin and gabapentin. The RP had briefed the team of the change in schedule of gabapentin and pregabalin.

The pharmacy supplied approximately 20 people their medication in multi-compartment compliance packs. They had previously supplied a care home but no longer did this. A further 10 people collected their compliance aids from the pharmacy although these were prepared at the Ockenden branch which had a robotic system. These people would liaise with the pharmacist at the other branch if they had any queries. The pharmacy had an established workflow in place to manage the service. People were divided into weeks and prescriptions were ordered by the pharmacy a week in advance of when the trays were due to be made. When the prescription was received it was checked against the previous history on the patient medication record (PMR). As the pharmacy was closely situated to the surgery they were notified of changes and sent discharge summaries from the hospital by the surgery team.

Assembled trays observed were labelled with product descriptions, mandatory warnings and there was also an audit trail in place to show who had prepared and checked the pack. Patient information leaflets were not routinely handed out and the backing sheets were loose.

Deliveries were carried out by a designated driver who was employed by the parent company. Signatures were obtained when people's medicines were delivered. In the event that someone was unavailable, medicines were returned to the pharmacy.

Signed and in date Patient Group Direction (PGDs) were in place for the services provided.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs. Fridge temperatures were said to be monitored daily and recorded; however, these were not available to see on the Proscript system. At the time of the inspection the temperature on the fixed reader was showing as 4.1 degrees Celsius with the minimum temperature at 4.0 degrees Celsius and the maximum at 9.3 degrees Celsius. The external probe which had been calibrated was not working. This made it harder for the pharmacy to show that it was keeping these medicines at the right temperature. CDs were kept under safe custody in the CD cabinet.

Date checking was completed by the dispensary team with members each allocated sections. Sections were checked every three months. Short dated stickers were used and a date checking matrix was in place. No date expired medicines were found on the shelves sampled.

The pharmacy had registered with SecurMed for the Falsified Medicines Directive (FMD) but had not had the software installed to use the system. The RP said that this was being dealt with by the owners and she was unsure of when it was due to be fitted. This means that the pharmacy cannot yet fully comply with the FMD requirements.

Out of date and other waste medicines were segregated and then collected by licensed waste collectors.

Drug alerts and recalls were received via emails from head office and a notification form had to be sent back once stock had been checked. The last actioned alert had been for losartan. Alerts could be checked by the RP, ACT and dispensers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services.

Inspector's evidence

The pharmacy had glass, crown stamped measures, and tablet counting equipment. Equipment was clean and ready for use.

Up-to-date reference sources were available including access to the internet.

A blood pressure monitor was available which was occasionally used as part of the MUR service. The RP said that this was replaced annually.

The pharmacy had a fridge of adequate size and a legally compliant CD cabinet.

The pharmacy's computers were password protected and screens faced away from the public. Confidential paperwork and dispensing labels were shredded.

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.