General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hobbs Pharmacy, Tonbridge Medical Centre, 1 River Lawn Road, Tonbridge, Kent, TN9 1EP

Pharmacy reference: 9011488

Type of pharmacy: Community

Date of inspection: 14/12/2021

Pharmacy context

The pharmacy is next to a medical centre in Tonbridge town centre. It receives around 95% of its prescriptions electronically. The people who use the pharmacy are mainly older people. The pharmacy provides a range of services, including the New Medicine Service, stop smoking service, emergency hormonal contraception, needle exchange, Get It card (condoms) and influenza vaccinations. And the pharmacy provides people with Covid-19 lateral flow test kits. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy 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. And it provides substance misuse medications to a small number of people. The inspection was carried out during the Covid-19 pandemic.

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	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 adequately 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. And it uses this information to help make its services safer and reduce any future risk. It protects people's personal information. And people can feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people. And the pharmacy mostly makes 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. And it had carried out workplace risk assessments in relation to Covid-19. There were documented, up-to-date standard operating procedures (SOPs), and the pharmacy reported and reviewed its dispensing mistakes. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members 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. And the outcomes from the reviews were discussed openly during the regular team meetings. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacy technician explained that the medicines were kept with the incident report form so that these could be referred to if there was a query. A recent error had occurred where the wrong strength of medicine had been supplied to a person. The packaging was very similar, and this had likely contributed to the mistake. The patient returned the incorrect item and was provided with the right medicine. The incident was reported to the pharmacy's head office and the person's GP, and it was recorded on the National Reporting and Learning System.

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 team could access the pharmacy if the pharmacist had not turned up in the morning. And they knew what tasks they should not carry out until there was a responsible pharmacist (RP) signed in. They also knew what they could and shouldn't do if the RP was not in the pharmacy.

The right RP notice was clearly displayed, and the RP record was completed correctly. Team members had signed to show that they had read, understood and agreed to follow the SOPs. The pharmacy had current professional indemnity and public liability insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. And there were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. 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 mostly completed correctly, but the prescriber's details were not always

recorded. 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.

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. The pharmacy team members had completed training about the General Data Protection Regulation (GDPR).

The pharmacy had previously carried out yearly patient satisfaction surveys, but because of the pandemic it had not carried one out for 2020 to 2021. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacist said that there had been a recent complaint, and this had been referred to the pharmacy's head office for it to be addressed.

The pharmacist and pharmacy technician 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 dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The delivery driver gave examples of action he had taken in response to safeguarding concerns. 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 trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular informal meetings. This means that they can help improve the systems in the pharmacy. 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, one pharmacy technician and two trained dispensers working during the inspection. Team members had completed accredited courses for their roles. And the pharmacy technician was planning to start an accuracy checking course. Workload was well managed, and the team worked well together and communicated effectively to ensure that tasks were prioritised.

The dispenser appeared confident when speaking with people, and she was aware of the restrictions on sales of products containing pseudoephedrine. She explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. And she used effective questioning techniques to establish whether the medicines were suitable for the person.

The pharmacist and pharmacy technician were aware of the continuing professional development requirement for the professional revalidation process. The pharmacist felt able to take professional decisions. And she said that she had completed declarations of competence and consultation skills for the services offered, as well as associated training. All team members working on the day of the inspection were trained healthy living champions. And some recent training undertaken by team members included; oral health, suicide awareness, obesity and Dementia friends. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacist said that she was planning to carry out appraisals and performance reviews. But these had not been carried out since the pharmacy had relocated. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions.

The team members explained that they discussed any issues and allocated tasks during the daily informal huddle. And information was regularly shared with other pharmacies in the company. The inspector discussed with the pharmacist about the reporting process if a team member tested positive for the coronavirus.

Targets were set for some of the services, but the pharmacist said that the pharmacy usually exceeded these. And she would not let the targets affect her professional judgement and provided the services for the benefit of people using the pharmacy.

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 had relocated one year ago. The premises was secured from unauthorised access, and it was bright, clean and tidy throughout. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There was a screen at the medicines counter to help minimise the spread of infection. The shop floor area was large enough allow people to maintain a suitable distance from each other. There were two chairs in the shop area for people to use. 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 could be accessed from the shop area and the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. It gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. The pharmacy dispenses medicines into multi-compartment compliance packs safely.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with an automatic door. 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 pharmacy was able to produce large print labels for people who needed these.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that she 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 Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these types of medicines being supplied when the prescription was no longer valid. Dispensed fridge items were not kept in dispensing bags and this helped team members to identify the medicines. The pharmacist said CDs and fridge items were checked with people when handing them out. 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 or warning cards available.

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. And the pharmacy kept lists of short-dated medicines and these were removed from dispensing stock and disposed of appropriately around one month before they were due to expire. There were no date-expired items found in with dispensing stock.

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 regularly, and the pharmacist explained that people were contacted after around three months to ask if they still needed the items. Any uncollected items were returned to dispensing stock where possible and prescriptions were returned to the NHS electronic system or to the prescriber.

The pharmacist said that people had assessments carried out by their GP 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. And there was a reliable system to manage this. The dispenser said that prescriptions for 'when required' medicines were not routinely requested. The pharmacy contacted people to ask if they needed them when their packs were due. 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. Team members wore gloves when handling medicines that were placed in these packs.

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 separated from other CD stock. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Deliveries were made by delivery drivers. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. When the person was not at home, the delivery was 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 driver delivered to the local area and returned to the pharmacy throughout his shift. He said that any fridge items were usually delivered within 30 minutes or they were returned to the pharmacy.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. 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.

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. Separate liquid measures were used to measure certain liquids to help minimise the risk of contamination. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around one year. The pharmacist said that it would be replaced in line with the manufacturer's guidance. The shredder was in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed. Team members wore face masks while at work, and hand sanitiser and gloves were available to help minimise the spread of infection.

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.