General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kington Pharmacy, 42 High Street, KINGTON, Herefordshire, HR5 3BJ

Pharmacy reference: 1031980

Type of pharmacy: Community

Date of inspection: 20/11/2019

Pharmacy context

The pharmacy is located on the main High Street of the market town of Kington. Most people who use the pharmacy are from the local area and there is a medical centre located on the outskirts of the town. The pharmacy dispenses prescriptions and sells a range of over-the-counter (OTC) medicines, as well as other health and beauty goods. It provides some medicines in multi-compartment compliance aid packs, to help make sure that people take them correctly and it also supplies medicines to a local nursing home. The pharmacy offers several other services including Medicines Use Reviews (MURs) and blood pressure testing. A substance misuse treatment service and needle exchange programme are also both available.

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 identifies and manages risks adequately. It has procedures to help make sure that it keeps people's private information safe and it maintains the records it needs to by law. Team members understand how to raise concerns to help protect the wellbeing of vulnerable people and they try to learn from their mistakes. But they are not always familiar with some of the pharmacy's written procedures, so they may not always work as effectively as they could.

Inspector's evidence

The pharmacy standard operating procedures (SOPs) covering operational tasks and activities. The procedures had been recently reviewed and defined the responsibilities of pharmacy team members. Signature sheets used to confirm staff acknowledgment were not fully complete, so the pharmacy may not always be able to clearly demonstrate that team members fully understanding their responsibilities. Through discussion the team members present had a general understanding of their roles, but one team member was not confident regarding the supply of pharmacy restricted medicines in the absence of a responsible pharmacist (RP). This was discussed with the team member on the day and the recently appointed non-pharmacist manager said that tasks such as the completion of SOPs were being reviewed now that she was in post. It was confirmed that the RP rarely left the premises and no absences had been recorded in the RP log. The locum pharmacist and the locum dispenser both had access to the current SOPs and they were made aware of any relevant updates. Indemnity insurance covering pharmacy services was provided through Numark and was valid until March 2020.

A current near miss log was available and team members recorded entries themselves. There were gaps in the log from the period between August 2018 and April 2019. The log was then in use again from August 2019 and more consistent records were seen to have been kept since this date. But there were some entries which were not recorded, which might mean that some underlying trends are not detected. The team discussed how near misses were reviewed but a record of this was not kept, so they may not always be able to show what they had learnt. The team were unaware of any specific changes that had been made in response to near misses or incidents. They said they were particularly careful with 'look alike, sound alike' medicines and tried to identify medicines with similar packaging. The locum pharmacist discussed the action that he would take in response to a dispensing incident. An incident reporting system was available and previous reports were filed in a patient safety folder. The team were unaware of any recent errors.

The pharmacy had a complaint procedure, which was displayed on a notice near to the medicine counter. The details were also recorded in a practice leaflet which was available for selection. Most people who used the pharmacy were from the local area and the team said that feedback was usually positive. A Community Pharmacy Patient Questionnaire (CPPQ) was ongoing at the time of the inspection and responses reviewed were positive.

The correct RP notice was displayed near to the medicine counter and the RP log was in order, as were records for private prescriptions and emergency supplies. And specials procurement records provided an audit trail from source to supply. The pharmacy CD registers usually kept a running balance and a patient returns CD register was available.

Pharmacy team members had completed information governance training. The pharmacy had a folder which contained several procedures. A copy of its privacy policy was not seen in the pharmacy on the day, but this was available on the pharmacy's website. The team discussed some of the ways in which patient information would be kept secure in the pharmacy, completed prescriptions faced away from public view and confidential waste was segregated and disposed of appropriately. Team members held their own NHS smartcards. The smartcard of one team member was observed to be in a computer terminal prior to her arrival at the premises, demonstrating that smartcards might not always be appropriately secured when not in use to help prevent unauthorised access.

Some signposting guidance documents were available at the pharmacy and the locum pharmacist had completed safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE). Several team members discussed some of the types of concerns that they might identify and explained how these would be managed. The contact details of local safeguarding agencies were available to support escalation.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members work in an open culture and can manage the current dispensing workload. Team members hold the appropriate qualifications for their roles or complete suitable training programmes. They get some ongoing learning and feedback on their development. But protected learning time is not always available, so team members may not always be able to stay up-to-date with their training.

Inspector's evidence

On the day of the inspection, a locum pharmacist was working alongside three dispensers, one of whom was a locum and another the non-pharmacist manager. A fourth dispenser arrived midway through the inspection. The pharmacy employed an additional dispenser, who was off sick and a part-time delivery driver. The pharmacy had previously had some staffing issues and for a period of time there had been no branch manager and no regular pharmacist. A dispenser had been employed as the non-pharmacist manager in the two-weeks prior to the inspection and a regular pharmacist had also been recruited, which had created more stability. A locum pharmacist had also been providing cover since another dispenser had left her post in May 2019. This cover was due to continue until the vacancy had been filled. The manager had identified several areas which required addressing and the team reported that things had been more organised in recent weeks. There was no backlog in dispensing on the day. Leave was planned in advance and the team reported that the workload was usually manageable with one team member absent. If required another local branch could be contacted for support. There were restrictions placed on leave to help maintain suitable staffing levels.

The pharmacy team members held the appropriate qualifications for the roles in which they were working and three of the dispensers were completing suitable training programmes. One of the dispensers was receiving support from a manager at a nearby branch, as there had been no designated pharmacy manager when she had begun her training. Training time was provided if required but work was usually done outside of working hours. The pharmacy provided additional training modules through an e-Learning system, but one dispenser had not completed any recent modules. The non-pharmacist manager discussed training and said that in the absence of a previous regular manager, there had been nobody present to monitor things such as training, but she was now assuming responsibility for this. The team had recently completed appraisals which reviewed their development and helped them set future learning objectives.

Sales were discussed with a dispenser who identified some of the questions that she would ask to help make sure that sales were suitable. The dispenser identified codeine-based medicines as being potentially high-risk and said that she would monitor for frequent requests. Concerns were referred to the pharmacist and the dispenser said that whilst training she often sought further advice.

There was an open dialogue amongst the team. They were happy to approach the locum pharmacist and the non-pharmacist manager, who had been identified for her new position by her colleagues. The regional leader could also be contacted if there were any concerns. The locum pharmacist said that in previous years he had contacted the superintendent pharmacist’s office for various reasons and would be comfortable to do so again, if the need ever occurred. The company had a helpline to support staff in raising concerns anonymously. The pharmacist discussed how the pharmacy patient medication

record (PMR) system was used to identify people who may be suitable for services and said that services were encouraged where they were appropriate for patients.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for the delivery of healthcare services. It has a consultation room to enable it to provide members of the public with access to an area for private and confidential discussion.

Inspector's evidence

The pharmacy was based inside an old traditional building on the High Street and it was in a suitable state of repair. Maintenance concerns were escalated to the company's head office, who arranged for any necessary repairs and the team completed housekeeping tasks. The pharmacy was generally clean and tidy on the day. There was adequate lighting throughout and the temperature was suitable for the storage of medicines.

The retail area was reasonably spacious and well organised. It portrayed a professional appearance with health promotion literature displayed and a range of goods which were suitable for a healthcare-based business. Pharmacy restricted medicines were secured from self-selection behind the medicine counter. The walkways were free from obstructions and there were chairs available for use by people waiting for their medicines.

Off the retail area was an enclosed consultation room. Access from the retail floor was restricted to help prevent unauthorised access. The room was clearly signposted, well maintained and equipped with a desk, seating and a computer to facilitate private and confidential discussions.

The dispensary had adequate space for the provision of pharmacy services. A main labelling terminal was situated on a front work bench and further work areas to the rear of the dispensary provided a space for prescription assembly, as well as a second labelling station. A further area was segregated for accuracy checking. The dispensary also had a sink for the preparation of medicines, which was equipped with suitable cleaning products.

Upstairs in the premises was a storage area, which had been fitted with several large work benches providing space for the assembly of prescriptions for the local nursing home and multi-compartment compliance aid packs. The room was appropriately maintained but did have several boxes temporarily stored on the floor, which may cause a trip hazard. Further staff areas and WC facilities were in a suitable state of repair.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services suitably, so people receive appropriate care. It gets its medicines from licensed wholesalers and team members carry out some checks to make sure that medicines are fit for supply. But people do not always receive patient leaflets with their medicines, so they might not get all the information they need to take their medicines properly.

Inspector's evidence

The pharmacy was accessed via a small step from the main street and it did not have a portable ramp, which may restrict accessibility for some individuals. Potential changes were restricted by the buildings listed status, but grab rails were fitted to help those with mobility issues and a bell was also available for any person requiring additional assistance. A dispenser reported that some customers who used mobility scooters used to bell to gain the attention of the pharmacy team, who then went to assist them at the doorway. The pharmacy had a hearing loop and the PMR system could generate large print labels to assist people with visual impairment.

The pharmacy's services were advertised in a display in the front window, along with the opening hours. As well as in a practice leaflet. There was additional health promotion literature displayed and the pharmacy had a small healthy living zone, showing materials for the current 'help us, help you' health campaign. Team members had access to resources to support signposting.

Prescriptions were segregated into coloured baskets to prioritise the workload and help prevent medicines being mixed up. Team members kept audit trails for dispensing by signing 'dispensed' and 'checked' boxes on dispensing labels. On the day of the inspection, there was a telecommunications issue affecting some stores within the area. This meant that the pharmacy was unable to access the internet and consequently they could not access the NHS spine. Prescriptions were primarily dispensed from one local medical centre, who were immediately informed of the issue and agreed to supply FP10 prescriptions, until the issue was resolved.

The team discussed how prescriptions for high-risk medicines were highlighted by using a 'pharmacist' sticker, audit trails of monitoring parameters were previously kept but had not been in recent months. The team agreed to review this moving forward. The pharmacist discussed the use of valproate-based medicines in people who may become pregnant. He discussed the counselling that would be provided and said that a record of this would be made on the PMR system. He was aware of the safety literature available, but this could not be located in the pharmacy on the day. The inspector advised on how further copies could be obtained.

Stickers were available to highlight prescriptions for CDs, but they were not always used consistently and an expired prescription for tramadol was identified in the prescription retrieval area. The team accepted that this may increase the risk that a supply could be made after the valid 28-day prescription expiry date.

The pharmacy offered a prescription collection service. People contacted the pharmacy to request their repeat prescription, and requests were sent to the GP surgery in sealed opaque bags. The pharmacy did not keep records of requests, so unreturned prescriptions may not always be proactively identified.

Signatures were obtained to confirm the secure delivery of medicines. Medications from failed deliveries were returned to the pharmacy.

The pharmacy supplied medicines to a local nursing home. Staff at the nursing home requested the medicines which were required each month and sent prescription orders directly to the GP surgery. They supplied the pharmacy with a picking list, so that unreturned prescriptions and prescription discrepancies could be identified. Medications were supplied in individual compliance aid packs, with a single medication in each pack. Some of the packs were ordered from a nearby hub as pre-packs and others were assembled on the premises. Compliance packs were supplied with accompanying administration record sheets, which provided the details of any topical or 'when required' medicines, which were not in compliance packs. Patient leaflets were not provided. This was discussed with the team, who agreed to review this moving forward. Feedback was sought from the nursing home to help make sure that any service issues were identified and addressed. A meeting was arranged for the coming weeks and previous feedback had been positive.

The pharmacy also supplied multi-compartment compliance aid packs to community-based patients. Most of which were assembled at a nearby dispensing hub. Medications were ordered by the pharmacy team on a four-week basis and each patient had a master profile, which recorded the details of their medicines. The record was updated with any changes that were made and a review of all records took place every six months to help make sure that they were current and accurate. Prescription details were clinically checked prior to being sent to the hub where dispensing took place. Completed compliance packs were then transported back to the pharmacy using tote boxes. Compliance packs were matched with the original prescription forms and any additional medications outside of the pack were dispensed. If the dispensing hub did not have stock of an item which should be placed into the compliance pack and could not source the stock from elsehwere, the pharmacy was informed of this and alternative treatments were discussed with the prescriber, before being dispensed locally, outside of the compliance pack. A professional standards manager explained that additional counselling would be provided at the point of collection, to help minimise the risk of any confusion to patients. Compliance packs were marked with descriptions of individual medicines and the team reported that no high-risk medicines were placed into compliance packs.

A needle exchange programme was available. People using the service requested the items required and the pharmacy made the relevant supply. Details were captured electronically as a record and the pharmacy had sharps bins for the suitable storage of returns. There were some team members who had not received a hepatitis b vaccination for personal protection and they could not recall any previous training on needle stick injuries, so they may not always be able to effectively manage this if the situation arose. A professional standards manager subsequently confirmed that a hepatitis b vaccination was available to all team members, in line with the requirements of the service specification, and that this had been reinforced with the team. A needle stick injury treatment poster was also confirmed as being available in the branch health and safety folder.

Stock medications were stored in the original packaging provided by the manufacturer and stock was generally organised. Team members kept some date checking records and the last checks had been conducted in July and September 2019. Short-dated medicines were highlighted, and no expired medicines were found during random samples. Obsolete medicines were placed into medicines waste bins. The pharmacy was not yet compliant with the requirements of the European Falsified Medicines Directive (FMD). Scanners had been installed in the pharmacy and the team were aware of some trials taking place in other branches, but they were not aware of the company's timeline for compliance. Alerts were received electronically and an audit trail confirming the action taken in response was maintained.

CDs were stored ensuring that returned and expired medicines were segregated from stock and CD denaturing kits were available. Both pharmacy refrigerators were fitted with maximum and minimum thermometers and the temperature was checked and recorded each day. No recent temperature deviations had been documented.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the equipment that it needs to provide its services and team members use equipment in a way that protects privacy.

Inspector's evidence

The pharmacy had access to paper reference texts including the British National Formulary (BNF) and they usually had a working internet access to support additional research. The pharmacist said that if essential he could access additional reference materials such as the Electronic Medicines Compendium (EMC) using internet access on his phone.

A range of glass crown-stamped measures were available for measuring liquids. Separate measures were marked for use with CDs. The pharmacy had counting triangles for loose tablets, and all equipment appeared clean and suitably maintained.

Electrical equipment had been recently PAT tested and appeared to be in safe working order. The computer system was password protected and screens were positioned out of public view. A cordless phone enabled conversations to take place in private, if required.

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.