General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kitsons Pharmacy, 8 Orchard Place, Barlaston, STOKE-ON-TRENT, Staffordshire, ST12 9DL

Pharmacy reference: 1037065

Type of pharmacy: Community

Date of inspection: 08/04/2019

Pharmacy context

This is a community pharmacy located in a parade of local shops within a village in Staffordshire. People using the pharmacy are from the village and the majority are from the older population. The pharmacy dispenses NHS prescriptions and provides some other NHS funded services. The pharmacy team dispenses medicines into weekly packs for people that can sometimes forget to take their medicines. The ownership of the pharmacy changed in November 2018 which has meant there have been some changes to the way the pharmacy runs.

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 aims to identify and manage risks associated with its services. It responds well to people's feedback and tries to make improvements to the quality of its services. But pharmacy team members do not always follow company procedures. This may increase the likelihood of mistakes happening, or mean they miss learning opportunities

Inspector's evidence

The ownership of the pharmacy changed from Kitson Chemist Ltd to Secret Potions Ltd on 2nd November 2018 and the staff had transferred from the previous company. The previous Superintendent (SI) had continues to work as the resident pharmacist and had stayed until January 2019 so that the busy period over Christmas was not impacted by the change of ownership. Four regular part-time pharmacists now worked at the pharmacy and head office was based not far from the pharmacy. The company's Compliance Manager was present during the inspection as she was working at the branch to provide cover in the dispensary for sickness.

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. The SOPs had been prepared and approved by the current Superintendent and had been issued to the branch at the end of January 2019. Signature sheets were available to record staff training. Training on the new SOPs was still in progress so there were gaps on the signature sheets. The SOPs did not make clear which SOPs were relevant for which job role, so staff working in the shop had signed SOPs for dispensary staff.

The procedure for recording and reviewing pharmacy incidents, such as dispensing errors or near misses, was not documented in the SOPs. The Compliance Manager explained this was an oversight and explained the process followed in their other branches; near misses should be recorded on the near miss log and errors should be recorded on an error reporting form and sent to the Superintendent. The process described by the Responsible Pharmacist (RP) was different to the company process and errors were recorded on the near miss log. This could mean that learning opportunities were missed as the review was limited and not shared with other branches in the company.

A near miss log from January 2019 onwards was available. The RP explained that each near miss was discussed with the dispenser at the time to see if there were any reasons for the near miss. Stickers had been used to highlight some medicines that had been involved in near misses i.e. escitalopram and enalapril and sertraline and sildenafil. The Compliance Manager had submitted an annual patient safety report for the NHS Quality Payment Scheme (QPS) but the RP was unaware of the outcome of the review or any patterns or trends for near misses. As the RP worked 2 days each week she was unsure whether the other pharmacists recorded near misses or any common patterns or themes.

Near miss logs from before January 2019 were not available as the RP thought that the previous owner had taken them with her when she had finished working at the pharmacy.

Members of the pharmacy team were generally knowledgeable about their roles and discussed these during the inspection. The medicine counter assistants were not sure about the legal restriction on pseudoephedrine sales and incorrectly explained that they would sell multiple packs. Questions related

to the tasks that could and couldn't be undertaken in the absence of the Responsible Pharmacist were answered correctly. Pharmacy staff were wearing uniform and name badges.

The complaints, comments and feedback process was explained to people in the practice leaflet and on a poster in the shop. People could give feedback to the pharmacy team in several different ways; verbal, written and the annual NHS CPPQ survey. The branch team tried to resolve issues that were within their control and explained that feedback from people using the pharmacy was generally positive. The team gave examples of when they had used feedback to improve their service. For example, a stand had been removed from the middle of the shop to make more space for seating and the repeat prescription collection service had been reviewed. A local surgery moved to a different location and people had mentioned that it would be more difficult to take their repeat requests in. So, the pharmacy now offered to take them on their behalf.

The pharmacy had up to date insurance arrangements in place. The Responsible Pharmacist (RP) notice was prominently displayed and the RP log was seen to be generally compliant with requirements. There were occasional instances where the RP entry was missing (15/2/19 and 15/2/19), so the log did not fully comply with the law. The RP log prior to 22/1/19 was not available for inspection as the RP thought the previous owner had taken it. Controlled drug (CD) registers were generally in order. A sample of private prescription records were seen to comply with requirements. Specials records were maintained with an audit trail from source to supply.

Confidential waste was stored separately to normal waste and shredded for destruction. No confidential information could be seen from the customer area. The Compliance Manager was in the process of completing the 2019 NHS Data Security and Protection Toolkit.

Pharmacy staff answered hypothetical safeguarding questions correctly. Staff gave examples of safeguarding concerns and explained how Dementia Friends training had been helpful. Local safeguarding contacts required updating although they were available on the internet if required. The RP had completed Centre for Pharmacy Postgraduate Training (CPPE) on safeguarding. A recent NHS contract monitoring visit had resulted in a request for the SOP to be updated to include more information about safeguarding and the Compliance Manager was working on this.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services. But pharmacy team members do not have formal training plans to make sure keep their skills and knowledge up to date. This may affect how well they care for people and the advice they give.

Inspector's evidence

The pharmacy team comprised of four part-time pharmacists, a pharmacy technician, a pharmacy student, a dispensing assistant, three medicine counter assistants and two staff working on a Saturday. Training certificates for two medicine counter assistants were displayed as evidence that accredited training courses had been completed. The Compliance Manager explained that the other medicine counter assistant and dispensing assistant had been asked to provide a copy of their training certificates as evidence of training and would be re-enrolled on an accredited course if they could not provide this evidence.

Two members of staff, plus a pharmacy student, worked in the pharmacy on a Saturday. The staff had been working at the pharmacy for longer than 12 weeks and had not been enrolled on an accredited training course. The Compliance Manager enrolled one on the medicine counter assistant course during the inspection. The other staff member was still in high school and mainly did shop tasks, such as cleaning and date checking, so enrolment on a course would be discussed with her when she was next at work.

Staffing levels were reviewed by head office and the RP felt that the current staffing level were adequate to meet the current workload. Pharmacy staff managed the workload well throughout the inspection and prioritised various tasks throughout the day. Three members of staff (a pharmacy technician, a dispensing assistant and a medicine counter assistant) were off sick at the time of inspection. The Compliance Manager was a pharmacy technician and was working at the branch to support during whilst the staff were absent.

Annual leave was requested in advance and the forms were sent to head office to be authorised. There was some confusion as to who was the line manager for the staff working in the pharmacy. Staff said they were unsure and would contact Head Office if they had any questions or concerns but the Compliance Manager said that their manager worked in another branch and they had been informed of this. The pharmacy staff said that they could discuss any ideas, concerns or suggestions with the pharmacists and would speak to the pharmacists or Head Office if they had any concerns.
The team were unsure of the appraisal process and could not recall when their last one was. There was no formal ongoing training programme or eLearning access. Some training linked to NHS Quality Payment Scheme had taken place i.e. Dementia Friends training and Oral Health training. Job descriptions were printed in the SOP folder.

The team appeared to work well together during the inspection and were observed helping each other and moving onto the healthcare counter when there was a queue. The RP was observed making herself available to discuss queries with people and giving advice when she handed out prescriptions. Targets were in place for services; the RP explained that she would use her professional judgment to offer services e.g. MURs when she felt that they were appropriate for the person.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services currently provided. But the consultation facilities are untidy which reduces the overall professional image.

Inspector's evidence

The pharmacy was smart in appearance and were well maintained. Any maintenance issues were reported to head office. The dispensary was compact and an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate worktops. A garage had been used for storage and this had not been included in the lease for the new owners. This reduced the amount of storage space that the pharmacy had. The consultation room was being used as a store room for boxes, bottles and shop items and the staff toilet was used for storing medicine disposal bins.

There was a private soundproof consultation room. The door to the consultation room remained closed when not in use. At the time of inspection, the consultation room was cluttered and was not professional in appearance. The introduction of some NHS services had been delayed due to the appearance of the consultation room. But, it was still being used for confidential conversations and medicine use reviews.

The dispensary was clean and tidy with no slip or trip hazards evident. The pharmacy was cleaned by pharmacy staff. The sink in the dispensary had hot and cold running water, hand towels and hand soap available. The sink next to the staff toilet did not have hot running water as the heater had broken. This meant that a member of staff could either wash their hands with cold water or walk through the dispensary to wash their hands in the dispensary sink. Neither was ideal in a healthcare environment.

The pharmacy had air conditioning and the temperature in the dispensary felt comfortable during the inspection. Portable heaters were used to heat the pharmacy and these had been PAT tested in December 2017. Lighting was adequate for the services provided. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally well managed. It sources and supplies medicines safely. But the pharmacy team does not store all stock medicines in appropriately labelled containers. This increases the chance that medicines could be given out when they have passed their 'use by' dates.

Inspector's evidence

The pharmacy was situated within a row of shops and there was a large, free car park for customers. There was a push/pull door and a small step. Staff worked in the shop and assisted people with the door when required, and a door-bell alerted staff to people that required assistance.

A range of health promotion leaflets and posters were available and pharmacy staff used local knowledge and the internet to support signposting. The pharmacy did not have a practice leaflet containing information such as the complaints procedure, how the pharmacy stores confidential information or the services available for people to freely take away.

Dispensing baskets were used to keep medication separate. Different coloured baskets were used to prioritise workload. A dispensing audit trail was seen to be in place for prescriptions through the practice of staff signing their initials on the dispensed and checked by boxes provided on medicine labels.

Weekly packs were dispensed for around 48 people. Prescriptions were ordered in advance to allow for any missing items to be queried with the surgery ahead of the intended date of collection or delivery. A sample of dispensed weekly packs were seen to have been labelled with descriptions of medication, an audit trail for who had been involved in the dispensing and checking process. Patient information leaflets were supplied monthly.

A prescription collection service was in operation. The pharmacy had audit trails in place for the prescription collection service and prescriptions collected were routinely checked against requests and discrepancies followed up. The pharmacy offered different services dependent on what the persons preference and what the surgery allowed.

Notes were attached to prescription bags to assist counselling and hand-out messages i.e. eligibility for a service, specific counselling or fridge item. A purple folder containing stickers, leaflets and information for ladies prescribed sodium valproate was available and staff were aware of the additional counselling required.

No out-of-date stock was seen during the inspection. The dispensary was date checked roughly every six months and recorded; the new SOP stated to date check the dispensary every three months. Short dated products were marked. Medicines were obtained from a range of licenced wholesalers.

Medicines were generally stored in an organised manner on the dispensary shelves although the amount of stock held was high and this reduced the amount of space available in the dispensary. There were several examples of medicines not being stored in their original packaging; some were loose blister strips on the shelf with batch number and expiry date on, some loose blisters had been cut and

did not have batch number and/or expiry date on and some had been put into boxes with different batches. Split liquid medicines with limited stability once opened were marked with a date of opening.

The pharmacy had barcode scanners and had registered with SecureMed for Falsified Medicines Directive (FMD) and were waiting for all staff to be present before they had training and started scanning medicines. The CD cabinet was secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. The CD keys were in the possession of the RP.

There was a fridge in place to hold stock medicines and assembled medicines. The medicines in the fridge were stored in an organised manner. Fridge temperature records were maintained and records showed that the pharmacy fridges were working within the required temperature range of 2°C and 8°C. Patient returned medicines were stored separately from stock medicines in designated bins. The pharmacy received MHRA drug alerts through NHS email. Each alert was printed and annotated to show it had been actioned and stored in a drug recall folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has most of the appropriate equipment and facilities to provide the services it offers.

Inspector's evidence

The pharmacy had a range of up to date reference sources, including BNF and cBNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken.

100ml and 50ml clean, crown stamped measures were available. Smaller measures that were suitable for measuring up to 10ml for liquid antibiotics were not available. Counting triangles were available. The pharmacy did not have a separate triangle for counting cytotoxic medication and did have some loose methotrexate in stock.

Patient medication records were stored electronically and access was password protected. Screens were not visible to the public as members of the public were excluded from the dispensary. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.