General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kays Chemist, 108 Bromham Road, BEDFORD, Bedfordshire, MK40 2QH

Pharmacy reference: 1028790

Type of pharmacy: Community

Date of inspection: 19/06/2024

Pharmacy context

This independent community pharmacy is located near to the centre of Bedford on a busy main road. Its main activity is dispensing NHS prescriptions. It also offers a range of other NHS services including the Pharmacy First service, emergency hormonal contraception, the hypertension case-finding service, seasonal flu vaccinations and the New Medicine Service. It delivers medicines to some people, and it supplies medicines in multi-compartment compliance packs to people who need this help to take their medicines at the right time. It provides a substance misuse service. And it dispenses medicines for residents of a small number of care homes.

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 identifies and manages risks well so that people receive safe services. It largely keeps the records it needs to, and it protects people's personal information. Its team members know how to protect vulnerable people and what they can and can't do in the absence of a pharmacist. The pharmacy uses mistakes as opportunities to learn and improve. But, because it doesn't always record these events, it might be missing patterns and trends.

Inspector's evidence

To manage the potential risks posed by the volume of prescriptions dispensed and providing an increasing number of other services, the pharmacy generally had two pharmacists on duty during opening hours. This meant the pharmacists could focus on different tasks and reduce the likelihood of mistakes happening due to distraction and interruption. To also help manage risks posed by distraction, different parts of the dispensary were used for various tasks. For example, multi-compartment compliance packs for people in their own homes and for care homes were prepared in a designated area towards the rear of the dispensary. This provided adequate clear bench space and a quieter environment to work in. There were audit trails on all dispensed items showing who had been involved in dispensing and accuracy checking each prescription. And there was a range of written standard operating procedures (SOPs) available for team members to refer to and which reflected the services provided by the pharmacy. The SOPs were due to have been reviewed in 2021 and 2022 but the reviews appeared to be outstanding. This could increase the chance that the SOPs didn't always reflect current best practice.

There was a process to record and review mistakes made during the dispensing process which were not spotted and rectified before leaving the pharmacy. These incidents were also reported online to the National Reporting and Learning System. Improvements had been made following previous incidents to reduce the likelihood of recurrence such as clearer separation of certain medicines with similar names or appearances. Mistakes that were spotted and corrected before leaving the pharmacy were discussed at the time they occurred and more broadly across the team to raise awareness, but these weren't always recorded. This could limit the ability of the pharmacy to detect any patterns and trends and make improvements to its processes.

When asked, members of the team could describe their roles and what they could and couldn't do if there was no pharmacist present. They understood that certain over-the-counter medicines could be misused or overused and could correctly describe how they would deal with repeat requests for these types of medicines.

The pharmacy had a complaints procedure and team members asked could explain how complaints would be handled. Generally, online feedback about the pharmacy was very positive and it was clear the team had a good rapport with customers visiting the pharmacy.

The pharmacy displayed a Responsible Pharmacist (RP) notice where members of the public could see it. The RP notice on display at the time of the inspection showed the correct information about the RP on duty. The pharmacy also kept an RP record showing who had been the RP when the pharmacy was

open. There was an electronic controlled drug (CD) register in use. A spot check of the physical stock of a sample of medicines agreed with the running balance recorded. Private prescriptions were recorded electronically. When a sample of private prescriptions was checked, the corresponding records did not always include the prescriber's details or the correct date of the prescription. This could mean the records are not always reliable in the event of a future query.

No confidential information was visible to people visiting the pharmacy. Confidential waste was separated from other waste and shredded on site. The team members could hold phone conversations about healthcare matters out of earshot of people in the shop. And team members had completed training about protecting people's sensitive information. The patient medication record system was password controlled and prescriptions waiting collection were stored out of sight and reach of the public. Team members had also completed training about safeguarding vulnerable people and there was an SOP for them to refer to. Examples were given of delivery drivers referring back concerns and queries to the pharmacist when they had encountered issues during medicine deliveries. Other examples were given of refusing supplies of substance misuse treatment to people who appeared to be intoxicated because of the health risks.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services safely. And its team members have either completed or are completing the right training for the roles they undertake. Team members can discuss concerns or other issues they may be having, in an open way. And there is some provision to help team members to keep their skills and knowledge current and to review how they are doing.

Inspector's evidence

At the time of the inspection, there were two pharmacists on duty (one of whom was the SI); this was a planned, regular occurrence to ensure dispensing and other services could be managed appropriately. The SI worked at the pharmacy on most days. The rest of the team comprised one pharmacy technician, two full-time trained dispensers and three full-time trainee dispensers. A foundation pharmacist was just about to sit their pre-registration exams. And the pharmacy also had two delivery drivers who worked part time. All team members had completed or were in the process of completing accredited training courses relevant to their roles. The team appeared to be managing the workload during the inspection and there was no apparent backlog of work. Holiday cover was planned in advance and shared amongst the team to ensure the pharmacy's services including preparing multi-compartment compliance packs, were maintained. The team members were observed working closely together and had a good rapport with their customers.

When asked, team members said they would be comfortable raising any issues or concerns with the SI. There was a whistleblowing policy in place and was highlighted to the team members. Less experienced members of the team including those in training could explain the circumstances when they would seek help from a pharmacist including making sales of medicines over the counter.

Team members had informal reviews with the SI every six months or so and there were team meetings on occasions to share information and discuss mistakes that had happened so the team could learn from these. Team members used industry publications and company materials to keep their skills and knowledge current. The SI explained how he had encouraged and supported the regular second pharmacist to develop their skills to provide some additional services including emergency contraception and travel vaccinations.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are well-maintained and are suitable for the services the pharmacy provides. People can have a conversation with a member of the pharmacy team in private.

Inspector's evidence

The external appearance of the pharmacy looked in reasonable order. The retail area and dispensary were clearly separated and there was a gate restricting access to behind the medicine counter. There were no slip or trip hazards or other obstructions in the retail area and some seating was available for people waiting for services. Lighting and ambient temperatures throughout the premises were suitable for the activities undertaken. All parts of the pharmacy including the sink used for preparing medicines and dispensing benches were reasonably clean.

There was a well-screened consultation room which could be accessed from the retail area and the dispensary. The room was lockable, had storage for equipment and sundries, and was kept clear of clutter. There was also access to patient medication records in the consultation room. Conversations inside the room could not be overheard from the shop floor.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and it tries to make its services accessible to people with differing needs. It takes care when supplying higher-risk medicines so people get the advice they need to take their medicines safely. And its team members liaise with other healthcare providers about people's care and the services the pharmacy provides when needed. It gets its medicines from appropriate sources, and it manages them reasonably well so they are safe to supply to people.

Inspector's evidence

The pharmacy entrance was at street level and the front door opened automatically, making it easier for people with mobility issues or with prams to enter. The pharmacy's opening hours and information about some of the services it offered were displayed in the windows. There were generally two pharmacists on duty meaning that dispensing activities could continue whilst other services such as Pharmacy first consultations were provided.

Though busy throughout the inspection, the team members were observed dispensing prescriptions in an organised way and responding to people coming into the pharmacy promptly. Dispensing labels were initialled at the dispensing and accuracy checking stages to provide a clear audit trail in the event of a future query. Warning stickers were applied to prescriptions that required extra care or storage arrangements, such as CDs and fridge lines. Or when the pharmacist needed to make extra checks with patients if they were receiving higher-risk medicines. The pharmacist gave examples of interventions the pharmacy had made about higher-risk medicines, including checking a starting dose of methotrexate after a break in treatment, to protect people. The pharmacy was aware of the updated guidance relating to the use of valproate-containing medicines by people who could become pregnant and only supplied these medicines in original packs with all the necessary safety information provided. The pharmacist also knew about the recent changes regarding puberty-blocking hormone treatments though hadn't received any prescriptions for these items in the past.

There were good processes followed to ensure multi-compartment compliance packs were prepared safely. Unexpected changes and missing items were queried. Packs were dispensed in a designated area and were sealed straightaway to prevent contamination or transfer between sections. Patient information leaflets were supplied to community patients routinely though not always to care homes. The pharmacy was advised to review this as it could mean carers did not have up-to-date information about the medicines readily available to refer to. The labelling on the packs seen included a description of the contents so people could more easily identify their medicines.

The pharmacists could refer to hard copies of the PGDs for the Pharmacy First service if needed. The service uptake had reduced somewhat since the initial launch. And there were problems obtaining some of the medicines that were authorised for supply. This meant, on occasions, the pharmacy had to refer people to their GP to get a prescription for alternative treatment. There had also been some confusion about inclusion and exclusion criteria and the pharmacy had had referrals to its service which were outside the scope of the service. This had created additional work for the pharmacy and inconvenience for people looking for treatment. The pharmacist had made local surgeries aware when these situations arose.

Medicines were obtained from a range of licensed wholesalers though national stock shortages meant the pharmacy was having to spend a lot of additional time sourcing medicines for people. There were good systems in place to check that items received were as ordered and to store medicines in an orderly way. Dates were added to liquid medicines on opening so assessments could be made as to their suitability to use when dispensing in future. Part-used packs were a highlighted using elastic bands to reduce the chance of supplying fewer doses than prescribed. And a red dot was added to packs of short-dated medicines so team members could assess if the medicines would remain in date for the expected duration of treatment. When spot checked, one date-expired medicine which did not have a red dot was found amongst other dispensing stock. Due to the volume of other activities, the pharmacy said that medicines were date checked on receipt and then routinely at the point of dispensing rather than using a date checking matrix. There was also one pack containing mixed brands of naproxen found. The pharmacy was advised against this practice as it could make it harder to date check and respond to product recalls effectively. The item was removed from the shelves. Medicines requiring refrigeration were kept in four pharmacy fridges and the temperature ranges of these were monitored and recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services effectively. It checks that its equipment is working correctly.

Inspector's evidence

Computer screens containing patient information could not be viewed by members of the public. The team had access to online reference sources to provide advice and undertake clinical checks based on current information. There was suitable equipment for disposing of sharps waste and medicine waste safely. Equipment required for providing Pharmacy First consultations, including an otoscope and ear thermometer, was readily available. The pharmacy used a computerised methadone measuring device to dispense methadone; this was calibrated each day and cleaned regularly. Other liquids were measured using calibrated glass measures and these were also clean. There was ample secure storage for CDs and sufficient refrigerated storage for medicines. There was no ice build-up in the fridges checked and the records kept indicated the fridges had remained within the appropriate temperature ranges for storing these medicines safely.

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.