General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Karsons Pharma, 33 Pattens Lane, CHATHAM, Kent, ME4 6JR

Pharmacy reference: 1032675

Type of pharmacy: Community

Date of inspection: 07/12/2021

Pharmacy context

The pharmacy is on a busy street near to a town centre in a largely residential area. It provides a range of services, including the New Medicine Service and a stop smoking service. And it receives around 90% of its prescriptions electronically. It also provides medicines as part of the Community Pharmacist Consultation Service (CPCS) and the GP CPCS. The pharmacy supplies medications in multi-compartment compliance packs to a small 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. Conditions on registration are in place on this pharmacy that prevent some services being provided. Theses conditions were imposed after failings were identified on a previous inspection and they remain in force at the time of this inspection.

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

Overall, 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. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information. And it largely keeps its records up to date and accurate, to show that its medicines are supplied safely and legally. Team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had carried out workplace risk assessments in relation to Covid-19. And it adopted adequate measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of 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 as a result of a recent near miss, lercanidipine and leflunomide were now kept separated. 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 dispenser said that there had not been any recent dispensing errors reported to the pharmacy. And the pharmacy kept a record of ones which had been previously reported to the pharmacy.

Workspace in the dispensary was limited, but it was free from clutter. And an organised workflow helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. 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 medicines counter assistant (MCA) said that team members would not be able to access the pharmacy until the pharmacist had turned up. She knew which tasks could be carried out if the pharmacist was not in the pharmacy during its opening hours.

The pharmacy had current professional indemnity and public liability insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The superintendent pharmacist (SI) said that a CD running balance check was carried out at regular intervals. And any liquid overage was recorded in the register. 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 correct prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The dispenser said that he would ensure that all the relevant information was

recorded correctly in future.

Confidential waste was removed by a specialist waste contractor, 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 dispenser explained that the operations manager had recently carried out pharmacy patient satisfaction surveys. The results from the surveys were not available during the inspection. The complaints procedure was available for team members to follow if needed and details about it were displayed in the shop area. Team members were not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided at the pharmacy. The SI said that there had not been any safeguarding concerns at the pharmacy. And the pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They are provided with structured training for their role. And they get time set aside in work to complete it. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist (the SI), one trained dispenser (NVQ Level 3 student), three trainee dispensers and one MCA working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. They communicated effectively and worked well together, to ensure that tasks were prioritised, and the workload was well managed.

The MCA appeared confident when speaking with people and she used effective questioning techniques to establish whether the medicines were suitable for the person. She was aware of the restrictions on sales of products containing pseudoephedrine. And 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.

Two of the trainee dispensers were on protected study time in the consultation room during the inspection. The NVQ level 3 student said that the course the trainee dispensers were on now included an accuracy checking module. But as he had started his course prior to this addition, he would have to complete separate training to enable him to be an accuracy checker. He was considering applying to join the pharmacy technician register once he had completed the final modules of the NVQ Level 3 course. The other trainee dispenser had only recently started working at the other pharmacy in the company. She was working at this pharmacy as it was not as busy and allowed her to take more time while dispensing items. The SI said that he was in regular contact with the NVQ tutors to ensure that the trainees were suitably progressing with their coursework. And to ensure that any issues were highlighted at the earliest opportunity.

The SI was aware of the continuing professional development requirement for the professional revalidation process. And he felt able to take professional decisions. He explained that he had been working at a local GP surgery for a few months and undertaken some recent pharmacist independent prescriber training. He had also spent time with an ENT hospital consultant and the local substance misuse team. And he had completed some training about antibiotic resistance, and asthma and COPD.

Team members felt comfortable about discussing any issues with the SI or making any suggestions. And any information was usually passed on informally during the day. The dispenser said that the operations manager carried out yearly appraisals and performance reviews for all staff. Targets were not set for team members.

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 was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter. And there was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was not available, but the room temperature on the day of the inspection was suitable for storing medicines. There was a small clear screen at the medicines counter to help reduce the spread of infection. The pharmacy was not limiting the number of people in the shop area, and the SI explained that people tended to not enter the pharmacy if they deemed that there were too many people already in it.

The pharmacy's consultation room 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 outside the room. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. And people with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. The consultation room was to the rear of the pharmacy and it was not accessible to wheelchair users, as there were several steps to negotiate. There was a room to the side of the pharmacy which would be used to have a private conversation. Services and opening times were clearly advertised, and a variety of health information leaflets was available.

Prescriptions for higher-risk medicines were dispensed when the person came to collect them. The SI explained that these medicines were handed out by him and he would speak with the person at that time to check that they were having the necessary tests. Prescriptions for Schedule 3 and 4 CDs were not dispensed until the person came to the pharmacy to collect them. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. The SI said that 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 and 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 few months were marked. There were a few boxes which contained mixed batches found with dispensing stock and one of the medicines in a box had expired. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The SI and dispenser said that they would ensure that medicines were kept in their original packaging in the future.

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. There weren't many dispensed items waiting collection. The SI explained that medicines were usually dispensed when the person come to collect them. There were a few prescriptions waiting to be collected which were no longer valid. The SI said that the bagged items would be checked more frequently. There were also some bagged items without a copy of the prescription attached. This could make it harder for team members to know that the prescription was still valid when the items were handed out. The SI said that the electronic prescription would be checked before the items were handed out. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The SI confirmed 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 the packs were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacy did not routinely request prescriptions for 'when required' medicines. The dispenser said that people would contact the pharmacy if they needed these medicines 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, but there was no audit trail to show who had checked each pack. This could make it harder for the pharmacy to identify who had done this task and limit the opportunities to learn from any mistakes. Medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The SI said that he would ensure that these were routinely supplied in the future.

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 segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Deliveries were made by a delivery driver. The driver also worked at another pharmacy within the company and the delivery record sheets were kept at that pharmacy. The SI said that the delivery driver maintained a suitable distance and was not asking people to sign for their items 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 SI said that the pharmacy would make several attempts to deliver people's medicines to them.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA via email. The dispenser explained the action the pharmacy took in response to any alerts or recalls. 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 and separate measures were used to measure marked for methadone use only. Triangle tablet counters were available and clean. Methotrexate came in foil packs and there was no need for the loose tablets to be counted out in a triangle. 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 was replaced in line with the manufacturer’s guidance. The carbon monoxide testing machine was calibrated by an outside agency. The phone in the dispensary was portable so it could be taken to a more private area where needed. Team members wore masks while at work. Hand sanitiser and other personal protective equipment was available in the pharmacy.

Fridge temperatures were checked daily, and 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.