

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: 03/04/2023

Pharmacy context

The pharmacy is on a parade of shops in a largely residential area. It provides an NHS dispensing service. The regular pharmacist is a prescriber and issues prescriptions as part of a walk-in service for acute illness and conditions for adults and children on a private healthcare basis. The pharmacy provides additional services including the New Medicine Service and Patient Group Directions for emergency hormonal contraception and the influenza vaccine. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to some 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 pharmacy receives most of its prescriptions electronically.

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

Overall, the pharmacy identifies and manages the risks associated with its services, including the prescribing service. It maintains appropriate consultation records and it monitors the prescribing service regularly. The pharmacy has appropriate indemnity arrangements to cover its prescribing activities. It has processes to protect vulnerable people. The pharmacy 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 regularly seeks feedback from people who use the prescribing service. The pharmacy largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy had completed a risk assessment to cover the prescribing service offered at the pharmacy premises. This risk assessment considered the likelihood of certain risks occurring and the potential consequences of each. And the pharmacy had identified what it could do to control these risks. And there was a plan to review the risks in a timely manner. The pharmacy had recently completed an audit which covered the prescribing service and wider elements of the pharmacy operation, such as staffing and information governance. All standards were met at the last audit. And the pharmacy had a plan to audit every three months to ensure compliance with relevant standards. The pharmacy had up-to-date standard operating procedures (SOPs) and team members had signed to show that they had read, understood, and agreed to follow them. 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. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. 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. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that he was not aware of any recent dispensing errors.

Workspace in the dispensary was limited but it was free from clutter. And 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. Prescriptions marked when clinically checked. The accuracy checking technician (ACT) knew which ones she could check and knew that she should not check those that she had dispensed.

The pharmacy had developed a SOP for the private prescribing service along with a flowchart for ease of reference. This SOP outlined the process of training requirements, initial triage, the consultation and included the prescribing process, and documentation requirements. This set out a clear process for the prescribing service including roles and accountability. People who used the prescribing service were given a paper prescription to take to another pharmacy. This ensured there was a separate clinical check performed on prescriptions issued by the pharmacy. The prescribing records were reviewed during the inspection and cross-referenced against the dispensing records. No evidence of prescriptions issued by the pharmacy's prescribing service being dispensed by the pharmacy was seen.

Team members said that the pharmacy would open if the pharmacist had not turned up in the morning. They were unsure about some of the tasks that should not be undertaken if there was no responsible pharmacist signed in. But they knew that they should not hand out dispensed medicines or sell pharmacy-only medicines if the pharmacist was not in the pharmacy. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up. Team members' roles and responsibilities were specified in the SOPs.

The pharmacy had appropriate insurances to cover its services, and this included its prescribing service. The private prescription records were mostly completed correctly, but the prescriber's name was not always recorded. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. 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 right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly.

The pharmacy's prescribing service used a standard consultation form template. This included key information such as the person's identifying information, general practice details, NHS number and date of birth. Additionally, the template included sections relating to the history of the person's ailment, the clinical examination and findings, and the management plan. Each consultation form had a section to provide consent to access the person's Summary Care Records and to share information with their GP. Consent was mandatory for all consultations as the pharmacy felt it was essential to provide a safe consultation. If consent was not provided, then the person was signposted to an alternative service, such as their own GP surgery or to NHS 111. The pharmacy had plans to develop an electronic record system for all consultation notes to be collected. A range of consultation documents were reviewed during the inspection. All consultations for urinary tract infections had urine dipstick testing performed to aid the diagnosis. Other elements of clinical examination included temperature, heart rate, oxygen saturations, blood pressure and respiratory rate. The pharmacist prescriber explained that this information was collected to exclude serious conditions such as sepsis. Consultation notes reviewed during the inspection also had evidence of exclusion of potentially serious symptoms such as confusion, blood loss etc. The consultation records documented details of advice given to people about what they should do if their condition worsened, and who they should contact if their symptoms did not improve.

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. Consultation records were stored in a lockable drawer in the consultation room which was accessible via lockable doors leading to the pharmacy dispensary.

People were given feedback forms after every consultation at the pharmacy for the prescribing service and people could also scan a QR code in the shop area to provide feedback. The pharmacist said that the operations manager collated the feedback. Team members said that there had not been any recent complaints. The complaints procedure was available for team members to follow if needed. After each prescribing consultation, people who used the service were given a feedback form to complete. Examples were seen during the inspection. And feedback from people was positive. The feedback forms gave people the opportunity to provide their own comments about the service.

Team members had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. They could describe potential signs that might indicate a safeguarding

concern and would refer any concerns to the pharmacist. And they said that there had not been any recent safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. Consultation records demonstrated that the prescriber considered safeguarding aspects when consulting with people using the pharmacy's prescribing service. The SI explained the process how followed if any safeguarding concerns were identified. This included contacting the local safeguarding leads, GP for the person involved and the police if concerns were sufficiently serious.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. The pharmacy can demonstrate that staff providing its prescribing service have done appropriate training for the conditions treated. There is a culture of collaboration and learning. And the pharmacy has networks within the local PCN.

Inspector's evidence

There was one pharmacist (who was the superintendent pharmacist and prescriber), one trainee ACT, one dispenser NVQ level 3 pharmacy student and one trained medicines counter assistant (MCA) working during the inspection. They communicated effectively during the inspection and ensured that the dispensing tasks were prioritised. This meant that the workload was well managed, and prescriptions were dispensed in a timely manner.

The volume of prescribing which happened at the pharmacy was sufficiently managed by the pharmacist. There was no backlog in documentation or processing of prescriptions for conditions assessed. This showed that the pharmacist was able to manage the workload associated with the prescribing service. There was another prescriber who was able to support the service if needed, although they were not actively prescribing for the pharmacy service at the time of the inspection.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine-containing products. She asked people questions to establish whether the medicines were suitable for the person before making a sale. And she said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care.

The pharmacist and ACT were aware of the continuing professional development (CPD) requirement for the professional revalidation process. The pharmacist had the relevant annotation on the professional register. And he had evidence of recent training to demonstrate his scope of competence. One example included attendance at a virtual training session about a month before the inspection. This session covered areas relating to ear, nose, and throat examination, respiratory, skin and women's health. Following the inspection, the further evidence of CPD was provided which included a record of training courses and work-based learning activities which the pharmacist had engaged with. And he also engaged with the local Primary Care Network and attended CPD events hosted by it.

The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. And they could usually complete this during quieter times or during their lunch break. Some team members said that they undertook training in subjects that interested them and there was no formalised training programme. The MCA had completed an Understanding health improvement course. And said that she read up about new over-the-counter medicines. The pharmacy maintained professional subscriptions to publications to support the prescribing service and help the prescriber to remain up to date with recent developments. The pharmacy had a plan to develop a newsletter to share across partner pharmacies to share learning.

The pharmacy maintained records of previous prescribing decisions made for people using the service.

This helped the prescriber identify if a medicine was being requested with increased frequency. The pharmacist explained that the only prescribed when it was in his professional opinion safe and appropriate for the person seeking treatment. If he felt that it was not safe or appropriate to prescribe, the person would be referred onto another, more appropriate service.

Team members said that information was passed passing informally during the day and meetings were held when needed to discuss any issues. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they had ongoing appraisals and performance reviews.

Targets were not set for team members. The pharmacy operated a service model whereby the person using the service paid for a consultation with a prescriber, irrespective of a whether a prescription was issued. This helped reduce the risk of incentive to prescribe medicines for financial gain. The people using the prescribing service were given the opportunity to take any prescription generated to another pharmacy if they wished to.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the provision of its services. The premises have adequate provision for private consultations. And they are appropriately secured from unauthorised access.

Inspector's evidence

The pharmacy was bright, clean, and tidy throughout. It was secured from unauthorised access and the pharmacy-only medicines were kept behind the counter. 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 was suitable for storing medicines on the day of the inspection. The pharmacist said that the room temperature was monitored during the warmer months, and it was within the recommended range. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

The pharmacy provided its prescribing service in a consultation room which was located at the back of the premises. The lighting and temperature were appropriate for the service provided. And the room was sufficiently private with a door to the dispensary. Team members were observed to knock on the consultation room door before entering. The room was largely clean and appropriately hygienic. But some areas were a little dusty. This was highlighted and rectified during the inspection. The pharmacist said that he would ensure that these areas were kept clean in future. The consultation room was not accessible to wheelchair users. The pharmacist said that if a person wanted to talk with him in a more private setting, then he would invite them to the pharmacy when it was closed at lunch time, or they could call the pharmacy.

Principle 4 - Services ✓ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy's prescribing service is provided in a safe way. People can access it easily and are appropriately signposted to alternative providers for conditions which are not managed by the service. Information is verified by accessing people's summary medical records. And information is appropriately shared with people's regular prescribers to help ensure safe transfer of care. The pharmacy gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls.

Inspector's evidence

There was step-free access into the main pharmacy area 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. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy could produce large-print dispensing labels for people who needed them.

The prescribing service was accessible to people who visited the pharmacy seeking help for minor ailments. People could also be referred by their GP practice, although this prescribing service was operated privately, and not as part of an NHS contracted service. For people presenting with minor ailments which the prescribing service did not cater for, they were provided with signposting advice of alternative services they could access. Examples included most conditions affecting children and more serious illnesses or conditions which required a medical professional to manage. The pharmacy signposted people to their GP practice, NHS 111 or the local emergency department depending on the severity of the presenting condition. Following the prescribing service consultation, people had the option of calling the pharmacy for follow-up advice if they wished. And the pharmacy invited people to return for a follow-up consultation if they wished. People who used the service were sometimes followed up after their consultation to check how they were doing. This was at the discretion of the prescriber and not all people were followed up.

The pharmacy developed a dedicated formulary to support the prescribing service. And this outlined which medicines should be prescribed for the conditions treated. The formulary contained key information relating to conditions treated and included details of situations when referral to a medical practitioner was warranted. It was developed in a collaborative way with advice from multidisciplinary healthcare professionals such as general practitioners and advanced nurse practitioners. National guidance was used to inform the development of the formulary including that published by the National Institute for Health and Care excellence (NICE). The formulary was due for review at the time of the inspection.

The pharmacy required all people who used the service to consent to the prescriber to access their SCR. This was required to check the person's identity and to support safe consultation and prescribing. Notifications of prescribing were sent to the persons registered GP practice and this was outlined in the SOP for the private prescribing service. This was mandatory for all consultations.

The pharmacy service was described as 'low volume' with an average of two consultations per day. The most common conditions treated included tonsillitis and urinary tract infections. The volume of

consultations had reduced significantly since the previous inspections. And the SI explained they wished to ensure the correct governance was in place before expanding the service. During the inspection, 111 consultation records were identified since January 2023.

The pharmacy had plans to introduce a new digital prescribing system which would allow the identification of trends in prescribing and which people use the service multiple times. This would require individual login credentials so only the prescriber would be able to generate prescriptions and edit notes on this new system. The prescriber expressed their hope that this new digital collection of data would support and enhance their auditing arrangements.

The pharmacist said that he 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 higher-risk medicines were dispensed at the time the people came to collect. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were dispensed when the person presented to collect them. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. The pharmacist 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 (PPP). He said that if a person needed to be on the PPP, he would refer them to their GP. And he would make a note on their medication record.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every few months and this activity was recorded. Short-dated items were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. CDs were stored appropriately and securely. Denaturing kits were available for the safe destruction of CDs. The pharmacist said that people were signposted to another local pharmacy if they had CDs to return. The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist 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.

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. There were very few dispensed items waiting collection due to the pharmacy dispensing when the person presented to collect. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The trainee ACT said that people had assessments carried out by the pharmacy and this was sent to their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The trainee ACT said that people usually contacted the pharmacy 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. But the 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 trainee ACT said that she would ensure that these were supplied in future.

Deliveries were made by a delivery driver. The trainee ACT said that the pharmacy obtained people's signatures for deliveries where possible, and these were recorded in a way so that another person's information was protected. The delivery sheets were kept at the other pharmacy. 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.

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

The pharmacy had suitable equipment to support the delivery of the prescribing service. This included an otoscope (used to inspect the ear canal and ear drum), urine dipsticks (to test urine for signs of infection, among other things), an automatic blood pressure machine, a stethoscope (used to listen to the chest) and a pulse oximeter (used to measure the oxygen saturation of a person). The pharmacist explained that equipment was cleaned with alcohol wipes before and after use. Some of this equipment was a little dusty due to infrequent use. But the pharmacist promptly cleaned the equipment when this was highlighted. The pharmacy had suitable equipment for measuring liquids and counting tablets, and these were clean. Separate liquid measures were used to measure marked for certain medicines only. And a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor was replaced in line with the manufacturer's guidance. The shredder appeared to be in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

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.