General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kamsons Pharmacy, 29 Darnley Road, Strood, ROCHESTER, Kent, ME2 2EU

Pharmacy reference: 1032904

Type of pharmacy: Community

Date of inspection: 16/01/2020

Pharmacy context

The pharmacy is located on a parade of shops opposite to a surgery, and in a largely residential area, near to a high street in Strood. The people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations (seasonal). It also provides medicines as part of the Community Pharmacist Consultation Service. It 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.

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 adequately identifies and manages the risks associated with its services to help provide them safely. The team members know how to protect the welfare of vulnerable people and they protect people's personal information well. The pharmacy regularly seeks feedback from people who use the pharmacy. And it largely keeps its records up to date and accurate. But it doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs). Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. The pharmacist explained that some near misses had previously been recorded on the near miss record, but the team had not been recording them recently. The pharmacist printed a more comprehensive near miss log during the inspection and said that he would use this in the future. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Near misses had previously been reviewed regularly, and the outcomes from the reviews had been discussed openly during the team meetings. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The person had realised the error and had not taken of the incorrect medicine. The pharmacy had apologised to the person for the error and the correct medicine was dispensed. The incident was discussed with team members and they were reminded to take care when dispensing medicines with similar names.

Workspace in the dispensary was free from clutter. 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. The accuracy checking technician (ACT) knew which prescriptions she could check and knew that she should not check items if she had been involved with dispensing them.

Team members' roles and responsibilities were specified in the SOPs. The ACT said that the pharmacy's head office would be contacted it the pharmacist had not turned up. Team members were not aware that the pharmacy could not sell General Sales List medicines if there was no responsible pharmacist (RP), and they thought they were allowed to carry out dispensing tasks before the pharmacist had turned up. They knew that they should not hand out any dispensed items or sell pharmacy-only medicines if the pharmacist was absent from the pharmacy during the working day. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up. The pharmacist printed a notice to remind team members about which tasks which could not be carried out if there was no pharmacist and he displayed this in the pharmacy for team members to refer to where needed.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were

complete. All necessary information was recorded when a supply of an unlicensed medicine was made. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Liquid overage was 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 responsible pharmacist (RP) log was completed correctly the correct RP notice was clearly displayed. The private prescription records were mostly completed correctly, but the prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. There were several private prescriptions that did not have the required information on them when the supply was made. The pharmacist said that he would contact the prescriber and request that all future prescriptions have all the required information recorded. The nature of the emergency was not routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query.

Confidential waste was segregated and 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 pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2017 to 2018 survey were available on the NHS website. Results were positive and 100% of respondents were satisfied with the efficient service. The complaints procedure was available for team members to follow if needed and details about it were displayed in the shop area. The pharmacist said that there had not been any recent complaints.

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

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. 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. And the team discusses adverse incidents and uses these to learn and improve.

Inspector's evidence

There was one pharmacist, one ACT, one trained dispenser, one trainee dispenser and two trained medicines counter assistants (MCAs) working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

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

Team members undertook regular online training provided by the pharmacy's head office and this was monitored by the pharmacist. The MCA said that she could complete some training in the pharmacy during quieter periods, but she usually completed the training at home. The dispensary team members discussed any dispensing mistakes openly between them. The pharmacist and ACT were aware of the continuing professional development (CPD) requirement for the professional revalidation process. The ACT explained about some recent training she had undertaken, including back pain, asthma and erectile dysfunction. She said she had undertaken some training about erectile dysfunction due someone being prescribed a medicine which she had never heard of before. The ACT said that she completed an accredited dispenser checker course while working as a dispenser. But she had also completed another accredited checking course once she had completed the NVQ level 3 pharmacy course. She said that once she had completed the second checking course, she felt more confident in her ability as an accuracy checker.

The pharmacist said that he felt able to take professional decisions. He said that he had been appointed as the local Primary Care Network lead and he was due to attend a conference. He had completed declarations of competence and consultation skills for the services offered, as well as associated training. He explained that the company's cluster manager visited the pharmacy around four times a year and there was a yearly manager's conference held. This allowed the managers to discuss any new initiatives, training and included CPD. He had recently undertaken training about the travel vaccination service.

The ACT carried out yearly appraisals and performance reviews for team members. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. Information

was passed on informally each day and there was a weekly meeting held to ensure that any important information was passed on to all team members.

Targets were not set for team members. The pharmacist said that he carried out the services for the benefit of the people who used the services. He explained that head office would support the pharmacy and provide additional pharmacist cover if there were any services which needed to be carried out such as Medicines Use Reviews.

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. 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 available; the room temperature was suitable for storing medicines. The pharmacy underwent a refit around one year ago. This had made the dispensary area larger and cleared floor space in the shop area to create a larger waiting area.

There were four chairs in the shop area and these had arms to aid standing. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was located in the shop area. It could be accessed from the shop area and the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. And 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. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. It responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. The pharmacy dispenses medicines into multi-compartment compliance packs safely. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with an automatic door. Services and opening times were clearly advertised and a variety of health information leaflets was available.

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. The ACT said that prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. There were no prescriptions for these medicines found waiting collection on the day of the inspection. The pharmacy had carried out audits for any people taking lithium, naproxen or valproate medicines. The pharmacist said that a person taking lithium was referred to their GP as they had not been given a monitoring record book. He said that prescribers did not usually issue prescription for a higher-risk medicine if a person was due a blood test. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The ACT said they checked CDs and fridge items with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people, and there was one person in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy did not have additional patient information leaflets or warning cards available. But most of the valproate medicine boxes had the warning cards attached. The pharmacist said that he would order more cards from the manufacturer.

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 12 months was marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. The ACT explained that items which were not likely to be used were returned to the pharmacy's head office to be re-distributed to other pharmacies within the company.

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, but not collected. This made it more difficult for the pharmacy to refer to the prescription to ensure that it was still valid when the items were handed out. The pharmacist said that he would ensure that the prescriptions were kept with the items until they were collected. Uncollected prescriptions were checked monthly. Items uncollected after two months were returned to dispensing stock where possible. The ACT explained that

prescriptions were kept at the pharmacy until no longer valid and then they were returned to the prescriber.

The ACT said that people's GPs carried out assessments for people receiving their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in these 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 ACT said that people ordered prescriptions for these 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 generally 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 pharmacist said that he would ensure that these were supplied in the future.

CDs were largely 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 largely destroyed with a witness; two signatures were generally recorded.

Deliveries were made by a delivery driver. The pharmacist said that the pharmacy was trialling a hand-held electronic device which would allow the pharmacy to track the driver, give estimated delivery times and check delivery times and view signatures. The pharmacy currently did not always obtain people's signatures for deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. 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 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.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist said that team members had undertaken some training on how the system worked and written procedures were available. He was not sure when the pharmacy would be using the equipment fully.

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 there were separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean. The dispenser explained that the counters were cleaned after each use to help avoid any cross-contamination. 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 phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; 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.