General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kamsons Pharmacy, Lingwell Croft Surgery, 20 Shelldrake Drive, LEEDS, West Yorkshire, LS10 3NB

Pharmacy reference: 1081773

Type of pharmacy: Community

Date of inspection: 12/02/2020

Pharmacy context

The pharmacy is next door to a GP surgery in a large suburb of Leeds. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies some medicines in multi-compartment compliance packs to help some people take their medicines. And it delivers medication to people's homes. The pharmacy provides the supervised methadone consumption service. And a needle exchange service. The pharmacy provides the Community Pharmacist Consultation Service (CPCS).

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	1.2	Good practice	The pharmacy team members act competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again.
2. Staff	Good practice	2.2	Good practice	The pharmacy is good at providing team members with opportunities to develop their knowledge. And it gives team members regular feedback on their performance. So, they can keep their skills up-to-date and identify areas to develop their career.
		2.5	Good practice	The team members discuss and share ideas and they proactively identify improvements to the delivery of pharmacy services. The team members introduce processes to improve their efficiency and safety in the way they work.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy team members reach out to the community to promote health and wellbeing and their services. They pro-actively identify and address the specific needs of some people within the local community who do not have direct access to healthcare services. So, they can support people's health needs.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services. The pharmacy team members respond competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar errors happening again. The team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy has arrangements to protect people's private information. And it keeps most of the records it needs to by law.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). The Superintendent Pharmacist regularly reviewed the SOPs. The SOPs provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The SOPs described the roles and responsibilities of the team. And each SOP listed the roles in the team the SOP related to. The team had read the SOPs and signed the SOPs signature sheets to show they understood and would follow the SOPs. The team demonstrated a clear understanding of their roles. And knew when to refer to the pharmacist. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacists and ACTs when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. A sample of the near miss error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error and actions they had taken to prevent the error happening again. The team reviewed these records each month to spot patterns and make changes to processes. The pharmacy team recorded dispensing incidents electronically. These were errors identified after the person had received their medicines. The pharmacy sent the report to head office. The team discussed the dispensing incident so everyone was aware of it and could learn from it. The team recorded the error on the person's electronic patient medication record (PMR) to remind all the team of the error and to help prevent the error happening again.

The pharmacy undertook a monthly patient safety review. One of the accuracy checking technicians (ACT) who was the assistant manager had recently taken on this role. The results of the review were shared with the team. The ACT was planning to produce a staff newsletter incorporating the results of the patient safety reviews. The pharmacy displayed posters in sections of the dispensary stating that the area was a designated quiet zone and to not disturb the team member working in the area. The team attached stickers to shelves holding medicines that looked alike and sounded alike (LASA) to prompt the team members to check the medicines they picked. The team had also separated LASA medicines such as amlodipine and amitriptyline. And it used the robot to store medicines at greater risk of being picked in error. As the robot provided a higher level of accuracy. The team also attached stickers to the shelves prompting them to check the strength of the medicines selected. These stickers were attached to shelves holding medicines that were often involved with errors. The pharmacy completed six month and annual patient safety reports. Latest reports reminded the team to ensure

stock was correctly placed in to the robot. The team was also alerted to the issue of team members signing the dispensed by box on the dispensing label before attaching it to the medicine. So, they were not doing a self-check of the medicines picked before signing off their work.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a poster providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy displayed the results in the retail area and published them on the NHS.uk website. The team members discussed complaints raised by people about waiting times. And how they could reduce the waiting times. The team members working on the pharmacy counter were encouraged to call out to colleagues to help them. And team members working in the rear of the dispensary looked for increased numbers of people presenting at the pharmacy counter. So, they could move to the pharmacy counter to help.

The pharmacy had electronic controlled drug (CD) registers. A sample looked at found that they met legal requirements. The system captured the current stock balance for each CD register and prompted the team when a stock check was due. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist (RP) records looked at found that some entries did not have the time the pharmacist stopped being the RP. The team members knew what activities could and could not take place in the absence of the RP. Records of private prescription supplies met legal requirements. A sample of records of emergency supplies of medicines found they met legal requirements including records of supplies from the Community Pharmacist Consultation Service (CPCS). A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed a privacy notice. And the team had signed confidentiality agreements. The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and the team members had access to contact numbers for local safeguarding teams. The pharmacists and pharmacy technicians had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team had signed safeguarding statements indicating they knew what actions to take when safeguarding concerns arose. The team responded well when a safeguarding concern occurred.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has a large team with the qualifications and skills to support the pharmacy's services. The pharmacy is good at providing team members with opportunities to develop their knowledge. And it gives team members regular feedback on their performance. So, they can keep their skills up to date and identify areas to develop their career. The pharmacy supports an open and honest culture within the team. The team members are good at supporting each other in their day-to-day work. They discuss and share ideas and they proactively identify improvements to the delivery of pharmacy services. The team members introduce processes to improve their efficiency and safety in the way they work.

Inspector's evidence

A full-time pharmacist manager and a part-time pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of two full-time accuracy checking technicians (ACTs), one of the ACTs was the assistant pharmacy manager, one full-time pharmacy technician, one full-time trainee pharmacy technician, two full-time qualified dispensers, one part-time qualified dispenser, three part-time medicines counter assistants (MCA), a part-time trainee MCA and two delivery drivers. At the time of the inspection the pharmacist manager, the regular pharmacist, the two ACTs, the pharmacy technician, the trainee technician, three dispensers and one MCA were on duty. The pharmacy displayed some of the team's training certificates for people using the pharmacy to see.

The pharmacy provided the team with extra training through e-learning modules. The assistant manager organised the training for the team. And identified topics the team would find helpful. The latest training was about Mental Health. The team members had protected time to complete the training. The assistant manager arranged for team members who were not confident with using computers to complete the training with colleagues who could provide support. The pharmacy kept a training matrix to show when each team member had completed the training. The team also read the newsletter sent from head office each month. The information in the newsletter included common errors made across the company for the team to be aware of and learn from. The assistant manager shared learning from their professional training courses such as look-alike and sound alike (LASA) medicines.

The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The team members were given the review template to complete before the meeting along with their job description and the form from the previous review. So, they had chance to reflect on their performance and achievements before the review meeting. The pharmacist manager had encouraged the trainee pharmacy technician to undertake the technician course. The trainee pharmacy technician identified that they spent a significant amount of time dispensing prescriptions for delivering to people. So, had taken the opportunity of the performance review to discuss working in other areas of the pharmacy. The trainee technician now spent time during the week working on the pharmacy counter to improve their knowledge and skills of over-the-counter medicines. The assistant manager had introduced a rota of tasks to share amongst the team. This ensured the team members had a range of skills, so they could support the pharmacy services in times of absence.

Team members could suggest changes to processes or new ideas of working. Team members who worked at the front section of the dispensary doing walk-in prescriptions and collections identified they were sometimes pulled away from their job to help someone at the pharmacy counter. The team had discussed this and now the team members working at the rear areas of the dispensary looked out for increased numbers at the pharmacy counter. So, they could move to the pharmacy counter to help. The pharmacy had targets for services and the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and the pharmacy had alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a sound proof consultation room. The team used this for private conversations with people. The pharmacy had a section of the pharmacy counter cordoned off. The pharmacy team used this for private conversations with people who did not want to use the consultation room. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team members provide services that support people's health needs. They reach out to the community to promote health and wellbeing and their services. The team members pro-actively identify and address the specific needs of some people within the local community who do not have direct access to healthcare services. So, they can support these people's health needs. The team manages the pharmacy services well. The team members check for issues that could affect the safe and effective delivery of services. And they pro-actively act to address any they find. The pharmacy team members keep records of prescription requests and deliveries. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines well.

Inspector's evidence

People accessed the pharmacy via a step-free entrance. The pharmacy displayed a GPhC poster explaining what people could expect from the pharmacy. The poster included a code for people to scan using their telephone to take them to the GPhC inspections website. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team had access to the internet to direct people to other healthcare services. The team wore name badges detailing their role. Some team members spoke different languages. So, they could help people asking for over-the-counter medicines. And help people understand the medication prescribed and how to take it.

The team had received several referrals from NHS 111 to the community pharmacist consultation service (CPCS). Some referrals from NHS 111 did not meet the criteria for the service so the team referred the person to other healthcare providers to help meet their needs. Or the team signposted the person to the urgent care centre close by. The pharmacist manager had arranged to spend time with a local NHS 111 team to see how the phone calls were processed. And the information the NHS 111 operator used when assessing if the person was suitable for the CPCS service. The pharmacist manager was the area manager for three other pharmacies. And was the community pharmacy lead within the local primacy care network (PCN) representing several local pharmacies. The pharmacist manager used the PCN role to encourage other pharmacists to take a pro-active role to help people presenting at the pharmacy asking for advice and medical treatments. Rather than referring them to other healthcare providers such as walk-in centres when treatments could be provided at the pharmacy. The pharmacist manager used the new medicine service (NMS) criteria to ask people prescribed a steroid inhaler if they were using less of their reliever inhaler. If the person said no the pharmacist invited the person in to the pharmacy to check their understanding of the steroid inhaler. And to see how they used their inhalers. The pharmacy had up-to-date patient group directions (PGDs). These gave the pharmacists the legal authority to provide the services such as the flu vaccinations and supplies of emergency hormonal contraception (EHC). The pharmacists completed risk assessments for the services provided. And kept records of the risk assessments.

The pharmacy provided multi-compartment compliance packs to help a large number of people take their medicines. People received monthly or weekly supplies depending on their needs. The full-time pharmacy technician managed the service. And got support from others in the team. To manage the workload the team divided the preparation of the packs across the month. And kept a list of when people were due their packs. So, everyone in the team knew when the person was due if they

contacted the pharmacy to ask about this. The team usually prepared the packs two weeks before supply. This allowed time to order the prescriptions and to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team members picked the stock before dispensing so they knew what medicines they had to order. The team used one section of the dispensary to dispense the medication. And a separate section for checking the packs. The team stored completed packs in a dedicated area. The team completed the weekly prescriptions as four weeks together. And stored them banded together with each prescription attached. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer's patient information leaflets. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items. And sent a copy to the GP team with a request for prescriptions when required. The team received forms from the GP teams about changes to people's medication. The form included the signature of the GP requesting the change. The team updated the person's electronic patient medication record (PMR) with the changes. The team kept the hospital discharge summaries and medication request forms with the medicine list to refer to if queries arose.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs (CD) cabinet in bags with the prescription attached. The team took the opportunity to speak to people using the needle exchange service about the safe use of needles when injecting. The pharmacist manager had liaised with the local council to raise awareness of the safe use of needles and the disposal of used needles amongst people who injected steroids. As this group usually did not have access to healthcare support and information. The team asked people what substance they were injecting so they could provide the correct equipment and advise the person on how to prevent infections at injection sites. The records kept for the service were anonymous. But the team advised people who attended for the methadone consumption service who also used the needle exchange service to speak to their key worker. So, the key worker could discuss the person's treatment and make any necessary changes.

The pharmacy provided a repeat prescription ordering service. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team members used the PMR as an audit trail to track the requests. The team regularly checked the system to identify missing prescriptions and chase them up with the GP teams. The pharmacy team had completed checks to identify people that met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found no-one who met the criteria. The pharmacy displayed a PPP poster to remind the team of the criteria and advice. The team completed checks with other people taking high-risk medicines such as methotrexate. And recorded details of these conversations on the PMR. The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The pharmacy had a robot installed. Each computer terminal in the dispensary was linked to the robot. A shoot delivered the medicine picked by the robot to each terminal for the dispenser to check the item picked and attach the dispensing label before the pharmacist did a final check.

The pharmacy used clear bags to hold dispensed fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and

prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacy had a separate stamp to record who had clinically checked, accuracy checked and dispensed the prescription. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy used an electronic system to record the deliveries due each day and allocate them to a driver via a smart phone App. So, the driver could see their deliveries due each day. The team added information such as prescriptions that included a fridge item or a controlled drug. So, the driver knew to ask a team member for these medicines. The driver used the smart phone App to get a signature from the person receiving the medication. The team members had access to the system so they could track the driver doing the deliveries and check the receipt of the medicine when queries arose.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 28 January 2020. The team used coloured dots to highlight medicines with a short expiry date. No out-of-date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of Oramorph oral solution with 90 days use once opened had a date of opening of 16 December 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy had equipment to meet the requirements of the Falsified Medicines Directive (FMD). But the team were not scanning the FMD compliant packs. Other pharmacies in the company were trialling the FMD equipment. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And the team mostly uses the pharmacy's facilities and equipment in a way to protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had fridges to store medicines kept at these temperatures. The team used different fridges to store medicine stock and completed prescriptions awaiting supply. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy mostly stored completed prescriptions away from public view. Some completed prescriptions were stored in boxes on shelves under the pharmacy counter. These were positioned so that the bag label with the person's name and address on was facing upwards. So, this information could be seen by people standing at this section of the pharmacy counter. The pharmacy held other private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.