

# Registered pharmacy inspection report

**Pharmacy Name:** Karsons Pharma, 69-71 City Way, ROCHESTER,  
Kent, ME1 2BA

**Pharmacy reference:** 1090819

**Type of pharmacy:** Community

**Date of inspection:** 09/07/2019

## Pharmacy context

The pharmacy is located on a main street in a residential area near to a large city and opposite a surgery. The pharmacy receives around 50% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, a stop smoking service and a needle exchange service. The pharmacy provides multi-compartment compliance packs to around 100 people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to around 30 people.

## Overall inspection outcome

### Standards not all met

**Required Action:** Improvement Action Plan

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
<b>1. Governance</b>	Standards not all met	1.7	Standard not met	The pharmacy does not always ensure that people's personal information is protected.
<b>2. Staff</b>	Standards not all met	2.2	Standard not met	Not all team members complete the required training for their role within the necessary timescale.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards not all met	4.2	Standard not met	The pharmacy sells pharmacy-only medicines at a counter which is not on the registered premises. This increases the risk that medicines are sold without the appropriate supervision.
		4.3	Standard not met	The pharmacy does not always store medicines which need cold storage properly. This makes it more difficult for the pharmacy to show that the medicines are safe to use. It does not always keep medicines in containers which are properly labelled. And this may increase the risk that date checks or product recalls are not effective. It does not always store medicines securely or in accordance with relevant legislation. This makes it harder to show that they are kept securely.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance Standards not all met

### Summary findings

The pharmacy does not always ensure that people's personal information is protected. It does take some steps to identify and manage the risks associated with its services and it regularly seeks feedback from people who use the pharmacy. It generally keeps its records up to date. And team members understand their role in protecting vulnerable people.

### Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included documented, up-to-date standard operating procedures (SOPs). The pre-registration pharmacy student explained that near misses were highlighted with the team member involved at the time of the incident. And that they identified and rectified their own mistakes. The pharmacist said that near misses were recorded and reviewed regularly for any patterns. The July log was available in the pharmacy. But it did not have any near misses recorded. There were logs for previous months and these appeared to have been reviewed. The pharmacist said that dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. But there were no recent incident reports available to view.

Workspace in the dispensary was largely 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 NVQ level 3 student said that she would not hand out dispensed items or sell pharmacy-only medicines if the pharmacist was not in the pharmacy. The pharmacist said that only pharmacists held keys to the pharmacy and it would not open if the pharmacist had not arrived.

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. The full prescriber details were not always completed on the private prescription record. This may make it harder for the pharmacy to identify the prescriber in the event of a query. There were no private prescriptions available to check during the inspection. The pharmacist said that these were kept in a locked filing cabinet and the person with the key was not working on the day of the inspection. 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. Controlled drug (CD) running balances were maintained and checked. Liquid methadone balances were checked frequently and overage was recorded in the register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) log was not always completed correctly. The pharmacist had completed the log prior to her finishing her shift on the day of the inspection. There were some days on which the QRP had not made an entry into the log. The pharmacist said that the pharmacy would have been open during those times. The pharmacist said that she would ensure that this was completed correctly in future. The correct RP notice was not displayed at the start of the inspection. The pharmacist changed this when the inspector pointed it out to her.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. There were some prescriptions visible through the dispensary windows and there were some prescriptions unsecured in one of the consultation rooms. This means that people's personal information could potentially be read by other people using the pharmacy and was not always kept securely.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2017 to 2018 survey were available on the NHS website. Results from the survey showed that 100% of respondents were satisfied with the pharmacy overall. The pharmacy had a complaints procedure for team members to follow if needed.

The pharmacist confirmed that she had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. And she confirmed that other team members had completed level one training. The trainee NVQ level 3 student 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 not all met

### Summary findings

The pharmacy generally has enough trained team members to provide its services safely but it does not always ensure that team complete the required pharmacy courses within the required time frame. This may mean that they may not have the knowledge and skills they need to do their tasks safely. Team members can raise concerns or make suggestions so they can help improve the systems in the pharmacy. They are provided with some ongoing training, but this is not always done on a regular basis. This may make it harder for them to keep their skills and knowledge up up-to-date.

### Inspector's evidence

There was one pharmacist, one pharmacy technician, one NVQ level 3 pharmacy student, one pre-registration pharmacy student, one trainee medicines counter assistant (MCA) and one trainee assistant (who had worked at the pharmacy for two days) working on the day of the inspection. The pharmacist said that the trainee assistant would be enrolled on an accredited pharmacy course within three months. The trainee MCA working on the medicines counter had worked at the pharmacy for around four years. She said that she had started an accredited counter assistant course some time ago but she had not finished it within the required time frame.

The team members wore smart uniforms. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The trainee assistant said that she would refer to the pharmacist if someone requested to purchase any medicine. The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. The trainee MCA 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. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The trainee MCA said that she was not undertaking any ongoing training on a regular basis. But she said that she had sometimes received product information from drugs representatives which she read through.

The trainee NVQ level 3 student said that she felt confident to discuss any issues with the pharmacist. She said that she was not aware if there were any meetings held and had worked at the pharmacy for around three months. She said that information was discussed informally throughout the day. The pharmacist said that she planned to have more formal meetings with team members to discuss any issues. Targets were not set for team members.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services.

### Inspector's evidence

The pharmacy was secured from unauthorised access. Most of the pharmacy-only medicines were kept behind the counter. But some of these could be reached by people using the pharmacy. There was a blind to cover them but it was not working on the day of the inspection. There was only one till in the shop area, and this was not on the registered premises; the pharmacy did not have a dedicated till point on the premises (see Principle 4 below).

There was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. The room temperature felt warm on the day of the inspection. The trainee MCA said that the air-conditioning had not worked for around one week. She confirmed that the room temperature was not monitored. The pharmacist said that the pharmacy was in the process of getting the air-conditioning fixed.

There were two chairs in the shop area. These were close to the dispensary counter, which could mean that other people could overhear conversations at the counter. There were boxes of prescription-only medicines kept where people using the pharmacy could potentially access them. Some boxes were moved to an area to the back of the pharmacy and a sliding gate was pulled across to help minimise the chance of these being accessed. But some boxes remained accessible to people using the pharmacy.

The consultation rooms were suitably equipped, well-screened and accessible to wheelchair users. Low level conversations in the rooms could not be heard from the shop area. The pharmacy's main consultation room was kept secure when not in use. The second consultation room was used by a chiropodist several times a week. There were some items in the room which were not secured properly. The pharmacist said that all these items would be removed from the room before it was used by the chiropodist.

Toilet facilities were clean and there were hand washing facilities available. The toilet area was used to keep needle exchange packs. The toilet was not kept secured when not in use and was potentially accessible to people using the pharmacy.

## Principle 4 - Services Standards not all met

### Summary findings

The pharmacy does not always provide its services safely. It sells pharmacy-only medicines from a till which is not on the registered premises. And this increases the risk that medicines are sold without the appropriate supervision. And it increases the risk that people are not given all the advice they need to take the medicines safely. It does not always ensure that medicines are kept secure or always store medicines which need cold storage properly. And it does not always keep medicines in containers which are properly labelled. This may increase the risk that date checks or product recalls are not effective. However, it does order its medicines from reputable suppliers. And 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. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. A variety of health information leaflets were available. Services and opening times were clearly advertised.

A small number of pharmacy-only medicines were on display in the shop area which was not on the registered premises. These were displayed on a till unit, and this was the only till in the shop. Consequently, the pharmacy-only medicines and some General Sales List medicines could only be sold at a till which was not on the registered premises. Tobacco products were also sold at this till.

Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. The trainee NVQ level 3 student was not aware of how long these prescriptions were valid for. The pharmacist said they checked CDs and fridge items with people when handing them out. She confirmed that the pharmacy supplied valproate medicines to a few people in the at-risk group. But it did not have the patient information leaflets or warning cards available. The pharmacist said that she would ensure that replacements were ordered from the manufacturer. There were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Short-dated items were not marked to indicate this, and lists were not kept for items approaching their expiry date. There were a few date-expired items found in with dispensing stock. And one item had expired in January 2019. There were several mixed batches found with dispensing stock. And some tablets were kept in dispensing bottles which were not correctly labelled and did not have batch numbers or expiry dates of the medicines recorded. This could make it harder for the pharmacy to respond to safety alerts or to date-check the medicines properly. Not all items in one of the consultation rooms were kept securely.

The pharmacy kept medicines requiring cold storage in several fridges and these were not overstocked. Two were in the kitchen and one was in the dispensary. Most of the fridges were suitable for storing medicines but one of them in the kitchen was a domestic type and contained drinks and food items. And medicines were kept inside this fridge. Maximum and minimum fridge temperatures were

recorded daily for the other fridges. And records indicated that these temperatures were consistently within the recommended range. But one of the fridges in the kitchen was showing to be out of range during the inspection. The trainee NVQ level 3 student said that she would reset the thermometer and recheck the temperature.

There were over 200 part-dispensed prescriptions at the pharmacy. The pre-registration pharmacy student said that it was sometimes difficult to locate prescriptions when people went to the pharmacy to collect the remainder of their medicines. There were several prescriptions for prescription-only medicines and CDs which were no longer valid. The pre-registration pharmacy student said that '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. There were several dispensed items waiting collection which had been dispensed more than six months ago. Prescriptions were not always kept with these items. This could make it harder for the team members to refer to the original prescription if there were any queries. Or to know if the prescription was still valid when handing out the medicines.

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 dispenser said that the pharmacy contacted people to see if they needed them. The pharmacy kept a record for each person which included any changes to their medication. They also kept 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 to identify the medicines. And patient information leaflets were routinely supplied.

CDs were mostly stored securely, but not all were kept in accordance with legislation. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned were not always recorded in the register promptly. Returned CDs were destroyed with a witness and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible. There were multiple details on each sheet. But the pharmacist said that the driver had been instructed to cover other people's information when signatures were recorded. If a 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. There were several deliveries that were recorded as being posted through people's letterboxes. The pharmacist said that people had requested for this to happen and it was not the usual practice.

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 pharmacist said that 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 installed for the implementation of the EU Falsified Medicines Directive. The pharmacist said that there was an SOP written for this procedure.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses some of this equipment to help protect people's personal information.

### Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring medicines was available. Separate measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. The shredder was in good working order. 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.