General Pharmaceutical Council

# 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:** 11/09/2023

## Pharmacy context

The pharmacy is in a convenience store on a busy main road in a largely residential area. It provides NHS dispensing services, the New Medicine Service and uses Patient Group Directions to supply emergency hormonal contraception and medicines to treat chlamydia. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. And it provides substance misuse medications to a large 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 adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it protects people's personal information. People can provide feedback about the pharmacy's services. And the pharmacy largely keeps its records up to date and accurate. Team members understand their role in protecting vulnerable people.

### Inspector's evidence

Team members had signed to show that they had read, understood, and agreed to follow the pharmacy's standard operating procedures (SOPs). One of the team explained that the pharmacist would make them aware of any near misses, where a dispensing mistake was identified before the medicine had reached a person. A team member said that the pharmacist would let them know their mistake and they would then rectify it. And near misses were recorded at the time of the mistake. A team member said that these were reviewed regularly for any patterns, but the results of the reviews were not fed back to the team. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist said that she was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. She said that these would be recorded, and a root cause analysis would be undertaken.

Team members knew which tasks they should not undertake if there was no responsible pharmacist (RP) signed in or if the pharmacist was not in the pharmacy. And team members' roles and responsibilities were specified in the SOPs. Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. And there was an organised workflow which helped staff to prioritise tasks and manage the workload. Workspace in the dispensary was largely free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription.

The pharmacy had current professional indemnity insurance. The pharmacist said that there were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were largely checked at regular intervals. Any liquid overage was recorded in the register. The recorded quantity of two CD items checked at random were the same as the physical amount of stock available. The right RP notice was clearly displayed, and the RP record was largely completed correctly. But there were several occasions when the pharmacist had not signed out when they had finished their shift and a different pharmacist was working the following day. This was discussed with the pharmacist during the inspection. The private prescription records were largely completed correctly, but the correct prescriber's details were not always 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 find these details if there was a future query. The pharmacist said that she would remind team members to complete the private prescription and emergency supply records fully in future.

Confidential waste was removed by a specialist waste contractor, computers were password protected

and people using the pharmacy could not see information on the computer screens. The pharmacist used her own smartcard to access the NHS electronic services. But another pharmacist's smartcard was also in use during the inspection, and they were not in the pharmacy. This was discussed with the pharmacist, and she said that she would remind team members not to share smartcards. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed. The pharmacist said that there had not been any recent complaints. One of the team said that they would refer any complaints to the pharmacist.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist had completed the Centre for Pharmacy Postgraduate Education level three training about protecting vulnerable people. And other team members had undertaken some safeguarding training. One of the team described potential signs that might indicate a safeguarding concern and said that they would refer any concerns to the pharmacist. Team members said that there had not been any safeguarding concerns at the pharmacy.

## 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. Team members can take professional decisions to ensure people taking medicines are safe. And they can raise any concerns.

### Inspector's evidence

There was one pharmacist, once pharmacy technician, three trained dispensers (two were on the NVQ level 3 pharmacy course) and one trainee medicines counter assistant (MCA) working during the inspection. There was also a member of staff who was undertaking administrative tasks. The pharmacy was up to date with its dispensing. And the team communicated effectively throughout the inspection to ensure that the tasks were prioritised, and the workload was well managed.

The trainee MCA appeared confident when speaking with people. She knew which questions to ask to establish whether the medicines were suitable for the person. And she asked specific questions for different medicines such as Ovex to ensure that people received appropriate treatment. She was aware of the restrictions on sales of pseudoephedrine-containing products. And 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 was aware of the continuing professional development requirement for professional revalidation. She said that she had recently completed the face-to-face training for COVID and flu vaccinations. Team members had either completed an accredited course, or they were enrolled on one. One team member had recently completed the NVQ 2 pharmacy course and said that she was due to be enrolled on the NVQ level 3 course. Team members said that they had been concentrating on completing their coursework. Team members said that they had to complete most of their training at home but could occasionally complete some at work during quieter times. Team members were not aware of any other training apart from this. The pharmacist said that she passed on pharmacy-related information that she thought was important to other team members on an ad hoc basis.

Team members said that the pharmacy used a messaging system to ensure that all information was passed on to all team members. And there was a morning huddle so that any issues could be discussed, and tasks could be allocated to team members. The pharmacist said that she felt able to make professional decisions. And she had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members said that they had regular performance reviews with their workplace supervisor while enrolled on the NCQ courses. This helped them to keep up with their coursework and discuss any issues. Team members felt comfortable about discussing any issues with the pharmacist. And the pharmacist felt able to speak with the other pharmacist or the superintendent pharmacist if needed. Targets were not set for team members.

## Principle 3 - Premises ✔ Standards met

### Summary findings

People can have a conversation with a team member in a private area. The premises are secure, but the pharmacy could do more to keep some areas tidy and free from clutter.

### Inspector's evidence

The pharmacy was secured from unauthorised access. A notice was displayed asking people not to go down the side of the dispensary without a team member. Pharmacy-only medicines were largely kept behind the counter, but there were several that were adjacent to the counter so were potentially accessible to people using the shop. The pharmacist said that there used to be a barrier to restrict access to those medicines, but this had been moved. She gave assurances that she would address this so that these medicines were not accessible to the public. 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. The pharmacy was bright and air conditioning was available. And the room temperatures were suitable for storing medicines. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

The pharmacy's main consultation room was to the rear of the dispensary. It was accessible to wheelchair users. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. A team member said that the room was rented out once a week, and if someone wanted a private conversation, the second consultation room would be used. The second consultation room was used for dispensing some medicines. It was cluttered, but a team member said that she would tidy it. There were some delivery boxes on the floor in the dispensary and these were potential tripping hazards for staff. There were a couple of unsealed delivery boxes near to the shop floor containing some prescription-only medicines. The inspector informed a team member about them, and she moved them to a more secure location.

## Principle 4 - Services ✔ Standards met

### Summary findings

People with a range of needs can access the pharmacy's services. 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. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

### 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. There was an entrance to the rear of the pharmacy which where people could collect their medicines with added privacy. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy could produce large-print labels for people who needed them.

The pharmacist said that prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that she would highlight prescriptions for these medicines in future and she would check that the person was having any relevant tests done at appropriate intervals. A team member said that prescriptions for Schedule 3 and 4 CDs were not highlighted but that prescriptions for these medicines would be highlighted in future. And this would help 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). The pharmacist said that they would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacy did not have the relevant patient information leaflets, warning cards or warning sticker available for use with split packs. The pharmacist said that she would order these from the manufacturer.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. She thought that a copy of any action taken was kept, but she was not sure where because the other pharmacist usually dealt with them. Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. Team members said that items with a short shelf-life were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. And there were no short-dated items found during the spot check. Bottles containing liquids which had a limited stability after opening were not always marked with the date opened. This meant that the pharmacy may not know if these medicines are still suitable to supply.

CDs were stored in accordance with legal requirements, and they were kept secure. Expired CDs were kept separated from dispensing stock CDs. And there were no CDs people had returned found during the inspection. The pharmacist said that the pharmacy recorded returned CDs at the time the pharmacy received them, and these were destroyed promptly. The fridges were suitable for storing medicines and were not overstocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the

recommended range. The large pharmaceutical fridge in the consultation room and the fridge in the dispensary were within the ranges on the day of the inspection. But the minimum temperature on the thermometer on the fridge in the kitchen was slightly below the appropriate range. The current temperature for that fridge was within the recommended range during the inspection. A team member reset the thermometer and it remained within the range. She said that she would re-check it and monitor it and would inform the pharmacist if it didn't main the right temperature.

A team member said that uncollected prescriptions were checked around once a month. Items remaining uncollected after around three months were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber. A team member said that part-dispensed prescriptions were checked monthly. And 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 was a large number of dispensing tokens in the retrieval that were no longer valid. The pharmacist said that she would remind team members to remove the expired tokens from the retrieval system in future. Dispensing tokens were not always kept with the dispensed items until collected. This could make it harder for a team members to know that the prescription was valid at the time of supply. The pharmacist said that she would remind team members to attach them in future.

People had assessments to show that they needed their medicines in multi-compartment compliance packs. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Team members explained that the prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacy did not routinely request prescriptions for 'when required' medicines. Team members said that people usually requested these directly from their GP when their packs were due. 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. Team members said that they would supply these in future. There were a few team members involved with assembling the packs and they could provide cover where needed.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. The driver initialled next to the person's details to indicate that the items had been delivered and she annotated on the sheet when she was not able to make a delivery. A team member said that returned deliveries were handed to a member of the dispensary team before the end of the working day. And 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

Up-to-date reference sources were available in the pharmacy and online. A team member said that the blood pressure monitor had been in use for a couple of months, and it would be replaced in line with the manufacturer’s guidance. The weighing scales were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

Suitable equipment for measuring liquids was available and clean. And separate liquid measures were used to measure marked for certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only and this helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

## 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. |