General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kamsons Pharmacy, 1 Windsor Street, LUTON, Bedfordshire, LU1 3UA

Pharmacy reference: 1094341

Type of pharmacy: Community

Date of inspection: 26/06/2019

Pharmacy context

The pharmacy is located within a health centre in a mixed commercial and residential area. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance packs (MDS blister packs) for people who have difficulty managing their medicines. Services include prescription collection and delivery, NHS urgent medicines and seasonal flu vaccination. The pharmacy has healthy living status.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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

The pharmacy's working practices are safe and effective. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk and keeps people's information safe. The pharmacy asks people for their views. The pharmacy has written procedures which tell staff how to complete tasks effectively. The pharmacy generally keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team members understand their role in protecting vulnerable people.

Inspector's evidence

Near misses were recorded and reviewed. Actions taken to prevent a repeat near miss were completed. Patient safety reviews were completed and included separating procyclidine and prochlorperazine following a picking error and ensuring fridge lines were not kept out of the fridge for too long awaiting checking. For the next year pharmacy aimed to reduce events involving 'Lookalike, soundalike' (LASA) medicines and date check medicines monthly. To minimise picking errors, lorazepam and loprazolam had been separated and co-codamol tablets and capsules had been separated. There was a folder of incident report forms including discrepancies with controlled drugs which had been reported to the accountable officer.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. Labels were generated and medicines were picked from reading the prescription. There were separate dispensing and checking areas. The pharmacist or accuracy checking technician performed the final check of prescriptions prior to completing the dispensing audit trail to identify who dispensed and checked medicines. The pharmacist initialled prescriptions suitable for accuracy checking technician final check and the accuracy checking technician did not final check any prescriptions she had dispensed herself.

There was a procedure for dealing with outstanding medication. The original prescription was retained, and an owing slip was issued to the patient. For "manufacturer cannot supply" items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary. The pharmacist could refer to a Department of Health list of alternative medicines which could be prescribed to manage supply.

Multi-compartment compliance packs (blister packs) were prepared for a number of patients according to a matrix which included patient details, date prescriptions were requested and received, when the blister pack was prepared, collection and delivery information and special notes. The pharmacy managed prescription re-ordering on behalf of patients. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a blister pack.

Individual patient notes were recorded on the patient medication record on the pharmacy computer. Discharge letters were retained in a folder. The backing sheet was printed off and checked against the prescription. Labelling included a description to identify individual medicines and patient information leaflets were supplied with each set of blister packs. High-risk medicines such as sodium valproate, controlled drugs and alendronate were generally supplied separately from the blister pack. Gloves were

worn to handle medicines during preparation.

The 2018 to 2019 annual community pharmacy patient questionnaire results were displayed and showed positive feedback. The complaints procedure was displayed. Standard operating procedures were due to be reviewed in Aug 2019. The procedures included responsible pharmacist and complaints procedures. The delivery drivers had trained in the written procedure for delivery of medicines outside the pharmacy. A staff member who served at the medicines counter said she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. Hydrocortisone cream would not be sold for use on the face. Solpadeine Max and Nurofen Plus would not be sold to the same patient at the same time because both medicines contained codeine.

There was a white board on which pharmacy tasks were recorded to prioritise tasks such as clearing owing prescriptions or activities to be completed between 6pm and 6.30pm. The staff break schedule was also recorded.

To protect patients receiving services, there was professional indemnity insurance in place provided by NPA expiring 31 Aug 2019. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. Records for private prescriptions did not always include the prescriber details. Emergency supply records were generally complete. Specials records were complete. The controlled drug registers were electronic and only the pharmacist entered any transactions (receipt or supply of controlled drugs). The balance of CDs was audited regularly monthly in line with the SOP. A check of actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. A random check of FP10MDA entries complied and the prescription was endorsed at the time of supply. Patient returned CDs were recorded in the destruction register for patient returned CDs.

Staff had completed or were in the process of re-training in General Data Protection Regulation (GDPR) procedures. There was a privacy notice on display and NHS ‘your data matters to us’. There were leaflets regarding patient information stored and how the pharmacy used it. Staff had signed confidentiality agreements. Confidentiality procedures had been part of the contract when two work experience students had been booked for their placement. Confidential waste paper was collected for shredding. Staff were using their own NHS cards.

Staff had completed safeguarding and dementia friends training. The delivery drivers were dementia friends. The pharmacist had completed accredited level two safeguarding training. There was a safeguarding procedure in the standard operating procedure folder.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members manage the workload within the pharmacy and work well together. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time pharmacist, one part-time pharmacist and regular locum pharmacists who covered set days, one full-time pre-registration pharmacist, one part-time accuracy checking technician, two full-time dispensers, three part-time dispensers, one part-time accuracy checking dispenser, two part-time medicines counter assistants, two part-time delivery drivers and a part-time student with mainly dispensing duties. The part-time student was enrolled on dispensing training following the visit. The regular pharmacist had been in post since Mar 2019.

The pharmacist was the pre-registration tutor. The pre-registration pharmacist was provided training through the company training scheme which included attending regular training days and a hospital placement. There were appraisals every thirteen weeks to monitor progress and the pre-registration pharmacist was allocated one-hour study time per day.

Staff studied any training materials provided in their own time and had completed Children's Oral Health on line. The pharmacist had completed risk management. There was an annual appraisal to monitor staff performance. There were no formal staff meetings, but the pharmacist spoke to staff as the need arose. Staff were able to provide feedback and the pharmacist had suggested that only the pharmacist would manage controlled drugs to minimise issues such as discrepancies. Staff had instigated an audit trail to manage query prescriptions returned to the surgery for amendment and return to the pharmacy. The whistleblowing policy was in the employee handbook.Staff said targets and incentives were set but not in a way that affected patient safety and wellbeing.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the provision of its services.

Inspector's evidence

The premises were clean and presented a professional image.Lavatory facilities were generally clean and handwashing equipment was provided. The consultation room was located to one side of the medicines counter. The consultation room was not locked when not in use but there were lockable cabinets to store equipment and documents. The computer screen was facing away from public view. The frosted glass door generally obscured the view from the public area of the pharmacy. There was a sink and handwash.There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective, and it gets its medicines from reputable sources. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. The pharmacy's team members are helpful and give advice to people about where they can get other support. They also make sure that people have all the information they need so that they can use their medicines safely. The pharmacy does not always keep a record of therapeutic monitoring checks, so it may not be able to show that appropriate counselling was provided to protect patient safety. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe and effective.

Inspector's evidence

There was wheelchair access and large font labels could be printed to assist visually impaired patients. Staff could converse in Urdu, French, Shona and Gujarati to assist patients whose first language was not English. Patients were signposted to other local services including the doctor or sexual health clinic to obtain emergency hormonal contraception. The pharmacist recorded interventions such as contacting the doctor regarding off-license use of medicines which included vitamin D doses locally. Prescriptions for more than 30 days supply of a controlled drug were queried with the prescriber.

Patients were counselled on how best to take their medicines and patients taking warfarin were asked if their yellow book was up to date. The dose of warfarin and time of dose was explained. Advice was given on interactions with food and medicines such as Daktarin oral gel which could affect INR. The INR was not always recorded on the patient medication record. Side effects of bleeding and bruising were explained to the patient. Patients taking methotrexate were reminded of the weekly dose and taking folic acid on a different day. There was a folder containing information on sodium valproate including the pregnancy prevention programme to be given when supplying sodium valproate to people in the at-risk group. The pharmacist was aware of the intervention and recording it on the patient medication record. The pharmacist explained the procedure and intervention recorded when supplying isotretinoin to people in the at-risk group.

There were warning stickers to highlight prescriptions containing high-risk medicines and requiring provision of counselling for the patient. 'Pharmacist' stickers were attached to prescriptions containing medicines including methotrexate and warfarin. Prescriptions for schedule 2,3 and 4 prescriptions were highlighted to ensure they were not given out after 28 days from the date of issue. Prescriptions not collected within three months were cleared from the prescription retrieval system.

The pharmacy had healthy living status at level one. The NHS email and nhs.uk entry was current. The pharmacy had conducted health campaigns including Stoptober, sun safety, keep active (walk to school) and children's oral health. There had been toothbrush cleaning charts to distribute to children encouraging oral health. Health information leaflets were displayed and included information on reducing weight and reducing the risk of different cancers. Audits were conducted for referral for prescription of proton pump inhibitor for gastric protection while taking non-steroidal anti-inflammatory drug (NSAID) and referral for a flu vaccination for diabetic patients. The previous pharmacist had conducted risk management on fridge items and minimised time out of fridge checking orders or dispensing. To minimise picking errors, lorazepam and loprazolam had been separated and

co-codamol tablets and capsules had been separated.

Medicines and medical devices were delivered outside the pharmacy by two trained delivery drivers. Delivery details were entered onto the Pro-delivery screen and linked to the driver’s device which the patient or their representative signed on receipt of their medicines.The pharmacist confirmed that pharmacy hardware and software was falsified medicines directive compliant and ready to use. The pharmacy team were in the process of writing procedures for the use of these.

Medicines and medical devices were obtained from Alliance, AAH and their own company's warehouse. Floor areas were clear, and stock was very neatly organised on the dispensary shelves. Stock was date checked and recorded. No date expired medicines were found in a random check. Liquid medicines were marked with the date of opening. Medicines were generally stored in original manufacturer’s packaging. Cold chain items were stored in the medical fridge. Waste medicines were stored separately from other stock. The pharmacist said they were uplifted by the contractor every two months and were removed shortly after the visit. The risk of diversion of waste medicines was discussed.

The pharmacist said there was low uptake of NHS Urgent Medicine Supply Advanced Service (NUMSAS). The pharmacy no longer offered a stop smoking service but supplied nicotine replacement treatment products against tokens provided to people at the surgery. Drug alerts were printed, checked and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Current reference sources included BNF and Drug Tariff. The medical fridge was in good working order. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius. The controlled drug cabinet was fixed with bolts. There was a range of British standard glass measures to measure liquids including separate marked measures for methadone which required treatment to remove lime scale. The sharps bin in the consultation room behind the pharmacist’s chair was moved to a lockable cabinet. The blood pressure monitor was new.

Prescriptions awaiting collection were stored on shelving near the medicines counter. The possibility that patient sensitive details may be visible to members of the public at the medicines counter was discussed. The pharmacist later confirmed that bagged prescriptions ‘ready for collection’ were being moved to a new more suitable location. The container of filed prescriptions awaiting collection was placed out of sight during the visit.

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.