General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kamsons Pharmacy, Eccleshill Health Centre, Newlands Way, BRADFORD, West Yorkshire, BD10 0JE

Pharmacy reference: 1099144

Type of pharmacy: Community

Date of inspection: 15/01/2020

Pharmacy context

The pharmacy is adjacent to a GP surgery and an out-of-hours and specialist care clinic in the suburbs of Bradford. And it is open six days a week. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MUR) and the NHS New Medicines Service (NMS). And they provide seasonal flu vaccinations. The pharmacy provides medicines to people in multi-compartment compliance packs to help them take their medicines safely.

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	1.2	Good practice	Pharmacy team members regularly record and discuss their errors. They analyse their errors for patterns. And make changes to improve safety based on the information available. They reflect on their changes to establish whether they have improved the quality of their services.
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 has procedures to identify and manage risks to its services. And pharmacy team members follow them to complete the required tasks safely and effectively. Pharmacy team members know how to safeguard the welfare of children and vulnerable adults. They protect people's confidential information. And keep the records they must by law. Pharmacy team members record and discuss mistakes that happen. They use this information well to learn and reduce the risk of further errors. And they read about mistakes that happen elsewhere to improve their practice.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. And the superintendent pharmacist (SI) reviewed them regularly. The sample checked were last reviewed in 2019. And the next review was scheduled for 2021. All the pharmacy's team members had read and signed the SOPs in 2019. The pharmacy defined the roles of the pharmacy team members in each SOP. Tasks were defined further by verbal discussions throughout the day.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes during their discussions with the pharmacist about what had happened. They discussed why the mistakes had happened. And they sometimes added information about the causes of errors to the records. The whole team had a brief discussion after each near-miss error where possible, to help respond quickly and make changes to prevent a recurrence. One example was pharmacy team members separating procyclidine and prochlorperazine on the pharmacy shelves after a picking error. And they had attached warning stickers to the shelves in front of each medicine to highlight the risks whilst dispensing. The pharmacist analysed the data collected about mistakes every month. And the examples of analysis seen were comprehensive, looking at patterns of errors and why they might have happened. The pharmacist explained she had recently discovered a pattern of an increased number of errors being made on a Tuesday and Friday. This had prompted her to review staffing levels. And she discovered that fewer team members worked on those days. She had discussed this with the team. And made an adjustment to staff hours, so more people were available at different times to deal with the workflow. The team's changes had resulted in fewer errors being made on a Tuesday and Friday. And there was evidence of this in the records kept. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using a template reporting form. And errors were reported to the SI. The examples of records available were comprehensive about what had happened. Errors were discussed with the team members involved. And they were shared with the whole team. Pharmacy team members discussed why the mistakes had happened. And proposed and implemented changes to help reduce the risk of them happening again. One example after a recent error was for the team to make sure the pharmacist was provided with original stock containers if medicines had been packed down in to a white carton. Pharmacy team members sometimes didn't record much information about the causes of their errors or the details of the changes they had made to help aid future reflection. But it was clear that these elements were discussed and appropriate changes were made.

The pharmacy received a regular bulletin from the company's head office each month, called "Kamsons Connect". The bulletin communicated various pieces of information to the team from around the company. And this included information about errors and patient safety incidents that had happened

elsewhere. All pharmacy team members read each bulletin. A recent bulletin had highlighted risks with common look-alike and sound-alike (LASA) medicines sildenafil, sumatriptan and sertraline. Pharmacy team members had moved each product to separate them from one another. And they had moved sildenafil to a drawer elsewhere in the dispensary. The bulletin had prompted the team to discuss other LASA medicines in the pharmacy. One team member suggested speaking the name of a LASA medicine as they selected them from the shelves. And this would help to prompt them to carefully look at the medicines name and prevent picking errors. Pharmacy team members could be heard speaking the names of medicines during the inspection. The pharmacist said she had seen a marked reduction in the number of errors involving LASA medicines since the had introduced the technique.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. The pharmacist explained that one area of feedback that the team could improve on had been their provision of healthy living advice to people. The team was working to improve this by making sure they displayed healthy living information clearly in the pharmacy. And by engaging people more proactively in discussions about their health.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity weekly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record electronically. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy team monitored and recorded fridge temperatures daily. They kept private prescription and emergency supply records electronically.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. The bags were sealed when they were full. And they were collected and returned to the company's warehouse for secure destruction. Pharmacy team members had completed online training about the General Data Protection Regulations in 2019. And they were clear about how important it was to protect confidentiality. There was a documented procedure in place detailing requirements under GDPR.

When asked about safeguarding, a pharmacy team member gave some examples of symptoms that would raise their concerns in both children and adults. They would refer their concerns to the pharmacist. The pharmacist explained she would assess the concerns. And she would seek advice from the area manager or local safeguarding teams if necessary. There was a documented procedure in place to help team members deal with a concern. And they displayed contact information for local safeguarding team in the dispensary. Pharmacy team members completed online training about safeguarding each year. And registered members of the team were required to complete supplementary training every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. Pharmacy team members complete training regularly to improve their knowledge and skills. They reflect on their own performance, discussing any training needs with the pharmacist and other team members. And they support each other to reach their learning goals. Pharmacy team members feel able to raise concerns and use their professional judgement.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist and three dispensers. The area manager was also present during some of the inspection. Pharmacy team members completed training ad-hoc by reading various trade press materials received in the pharmacy. And by having regular discussions with the pharmacists about current topics. They also attended various local training events where available. Pharmacy team members who attended the event fed back to the rest of the team to share what they had learnt. Pharmacy team members were not aware of an appraisal process. The dispenser advised that any learning needs would be discussed with the pharmacist informally. The pharmacist signposted team members to the most relevant sources of information and help. And provided support and teaching to help address any learning needs.

The pharmacy team communicated with an open working dialogue during the inspection. Pharmacy team members explained they would raise professional concerns with the pharmacist area manager or head office staff. They felt comfortable raising a concern. And confident that concerns would be considered, and changes would be made where they were needed. Pharmacy team members made changes after discussing areas for improvement in the pharmacy. They had changed the way they recorded and handled changes to medicines provided to people in multi-compartment compliance packs. They now recorded all changes on a dedicated record sheet. And the pharmacist confirmed the prescribed changes my accessing the person’s GP summary care records. The pharmacy had a whistleblowing policy. The instructions about how to access the procedure were clearly displayed to the team in the pharmacy. The company did not ask the pharmacy team to meet any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door. There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink providing hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy were maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people, including people using wheelchairs. And the pharmacy has systems in place to help provide its services safely and effectively. It stores, sources and manages its medicines appropriately. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. They manage this service well. And they provide these people with the information they need to identify their medicines in these packs. Pharmacy team members take steps to identify people taking high-risk medicines. They provide these people with relevant advice to help them take their medicines safely.

Inspector's evidence

The pharmacy was accessible via level access from the car park through an automatic door. Pharmacy team members described how they would help people access services. Such as using written communication with someone with hearing impairment. And providing people with a visual impairment with large-print labels and instructions sheets to help them take their medicines safely. The pharmacy displayed information about its service to people in the retail area.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. She checked if the person was aware of the risks if they became pregnant while taking the medicine. She gave them appropriate advice and counselling. And would refer people to their GP if they were not enrolled on a pregnancy prevention programme. The pharmacy had a supply of printed information material to give to people to help them understand the risks. Pharmacy team members had carried out an audit of their patients receiving prescriptions for valproate in November 2019, to help identify people that may need advice and referral to their doctor. The audit showed that they did not currently have any people that were at risk of becoming pregnant that were regularly receiving prescriptions for valproate. The pharmacist explained they used the patient's medication records (PMR) system to record when they gave someone advice about valproate. She said this meant they could generate a report of who had received counselling advice and when, to help plan when they might need to repeat the audit.

The pharmacy supplied medicines in multi-compartment compliance packs when requested. It attached labels to the pack, so people had written instructions of how to take their medicines. And pharmacy team members added descriptions of what the medicines looked like, so they could be identified in the pack. They provided people with patient information leaflets about their medicines each month. Pharmacy team members documented any changes to medicines provided in packs on the PMR. And on a change record sheet kept with each patient's master record. The pharmacist said she also confirmed any changes made by accessing the patients GP summary care records before implementing the necessary changes. The pharmacy delivered medicines to people. It recorded the deliveries made using an electronic system. Pharmacy team members used the system to populate a delivery run sheet for the driver, which included information about any controlled drugs (CDs) and fridge items. And any other special instructions for the driver. The run sheet was uploaded to the driver's hand-held device. People signed for their deliveries using the electronic device. And the pharmacy was able to track the driver's progress in real time. Pharmacy team members said this was especially useful if they received a query

about a delivery while the driver was out on his round.

The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves throughout the pharmacy. And all stock was kept in restricted areas of the premises where necessary. The pharmacy had scanners and equipment in place to help identify counterfeit medicines under the Falsified Medicines Directive (FMD). And pharmacy team members had been trained about FMD and the new equipment. The pharmacist explained the company were trialling a system to properly scan and decommission products. And the team were expecting the this to be fully implemented by the end of March 2020. The pharmacy had adequate disposal facilities available for unwanted medicines, including CDs. Pharmacy team members kept the CD cabinet tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members checked medicine expiry dates every month. And records were seen. They highlighted any short-dated items with a sticker on the pack up to 12 months in advance of its expiry. And any stock expiring was removed in the month before their expiry, at the latest. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The equipment available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy positioned computer terminals away from public view. And these were password protected. It stored medicines waiting to be collected behind the pharmacy counter, also away from public view. The pharmacy had a set of clean, well maintained measures available for medicines preparation. Pharmacy team members used a separate set of measures to dispense methadone. The dispensary fridge was in good working order. Pharmacy team members used it to store medicines only. They restricted access to all equipment and stored all items securely.

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.