General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kamsons Pharmacy, 23 London Road, SITTINGBOURNE, Kent, ME10 1NQ

Pharmacy reference: 1032967

Type of pharmacy: Community

Date of inspection: 13/03/2020

Pharmacy context

The pharmacy is located on a busy main road in a largely residential area. It is near to Sittingbourne town centre and it is part of a large multiple of around 75 pharmacies. The people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews and the New Medicine Service. And it supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information and people can provide feedback about the pharmacy's services. It largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted measures for identifying and managing risks associated with its activities. There were documented, up-to-date standard operating procedures (SOPs) available. Team members had signed to show that they had read, understood and agreed to follow the SOPs. Near misses were highlighted with the team member involved at the time of the incident; they generally identified and rectified their own mistakes. The pharmacist asked one of the dispensers to record a near miss during the inspection, but there was no sheet in the folder. He printed one during the inspection and said that near misses would be routinely recorded and reviewed regularly for patterns in the future. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing incidents where the product had been supplied to a person were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong type of medicine had been supplied to a person. They had similar names so they were now kept on separate shelves following the incident.

Workspace in the dispensary was 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.

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that she would contact the pharmacy's head office if the pharmacist had not turned up in the morning. She knew that she should not carry out any dispensing tasks until the pharmacist had assumed responsibility. Another dispenser said that she would not sell-any pharmacy-only medicines or hand out any dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. The emergency supply record was completed correctly and the electronic controlled drug (CD) registers examined were filled in correctly. The CD running balances were checked at regular intervals and the recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were largely completed correctly, but the prescriber's name was not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was largely completed correctly. But there were a few occasions recently where the pharmacist had not completed the record when they had finished their shift.

Confidential waste was removed by a specialist waste contractor, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards

used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy was in the process of carrying out a patient satisfaction survey. The dispenser said that these would be carried out yearly. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The dispenser said that she was not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. She 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 met

Summary findings

The pharmacy has enough trained team members to provide its services safely and they do the right training for their roles. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist (who was also the area manager), three trained dispensers and one trainee dispenser working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The dispensers appeared confident when speaking with people. One, when asked, was aware of the restrictions on sales of pseudoephedrine containing products. And she 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 dispenser said that team members were due to undertake regular ongoing training once the permanent pharmacist started working at the pharmacy. But they had been concentrating on the running of the pharmacy since the takeover. She said that the permanent pharmacist was due to start in April 2020. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He said that he felt able to take professional decisions. He explained that he was a pharmacist independent prescriber and he had recently undertaken some training about vaccination administration. He said that this had helped him to be able to answer complex queries from people. He said that he also managed the medicines for several people taking substance misuse medicines while he worked at a different pharmacy. He was responsible for managing their doses and writing prescriptions and he referred to the consultant where needed.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. One of the dispensers said that there were regular meetings before the pharmacy had changed hands. She said that team members felt fully supported while the transition took place and there were additional staff employed during the first week. Targets were not set for team members. The pharmacist said that the services were provided or the benefit of the people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind clear screens in the shop area and notices were clearly displayed asking people to seek assistance. 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. Air conditioning was not available; the room temperature was suitable for storing medicines on the day of the inspection. The dispensers said that the room temperature increased significantly in the warmer months. The pharmacist said that he would ensure that the temperatures were monitored and that any necessary action was taken where needed to ensure that the medicines were kept at appropriate temperatures.

There were four chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was located next to the medicines counter. It was suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area. Toilet and handwashing facilities were clean and not used for storing pharmacy items.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. 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. People with a range of needs can access the pharmacy's services. The pharmacy dispenses medicines into multi-compartment compliance packs safely. 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. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available.

Prescriptions for higher-risk medicines such as methotrexate and warfarin were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The dispensers said that the pharmacy did not keep a record of blood test results. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The dispensers said they checked CDs and fridge items with people when handing them out. 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. The pharmacy did not have the updated version of the relevant patient information leaflets or warning cards available. The dispenser said that she would order them from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next few months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Part-dispensed prescriptions were checked frequently. '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. And the prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The dispensers said that uncollected prescriptions were checked regularly and people were contacted if they had not collected their items after two months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The dispenser said that people who had their medicines in multi-compartment compliance packs were referred to the pharmacy by their GPs. Three team members managed the packs so that they could

cover for each other where needed. The pharmacy did not order prescriptions on behalf of people who received their medicines in multi-compartment compliance packs. The pharmacy kept a record for each person which included any changes to their medication and they also kept any 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 identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs where possible. One of the dispensers said that she was not able to wear the gloves so she used tweezers to handle the medicines. The packs were assembled in a room to the rear of the pharmacy to help minimise distractions.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. The pharmacy used a hand-held electronic device to record signatures and the deliveries could be tracked on the computer. This enabled the pharmacy to inform people when their medicines were due to be delivered if they asked. When the 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.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. 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 to be able to comply with the EU Falsified Medicines Directive but it was not yet being used. The pharmacist said that the pharmacy was waiting for the written procedures and then team members would be trained before the equipment was used.

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

Suitable equipment for measuring liquids was available. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. 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.

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

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and was not overstocked.

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.