General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kamsons Pharmacy, 9 Longridge Avenue, Saltdean, BRIGHTON, East Sussex, BN2 8LG

Pharmacy reference: 1036135

Type of pharmacy: Community

Date of inspection: 26/01/2024

Pharmacy context

This is a community pharmacy in a parade of shops, located in a seaside town. It mainly provides NHS services such as dispensing, the New Medicine Service, seasonal flu vaccinations, and supervised administration of some medicines. It delivers medicines to some people's homes. And it assembles medicines into multi-compartment compliance packs when people need this additional level of support. The pharmacy was previously owned by Lloyds and changed ownership in December 2023.

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 adequately identifies and manages the risks associated with its services. It largely keeps the records it needs to by law to show that it supplies medicines safely and legally. Team members know how to respond to concerns about the welfare of a vulnerable person. And they protect people's personal information well. People using the pharmacy can provide feedback or make complaints about the pharmacy's services.

Inspector's evidence

There was a range of standard operating procedures (SOPs) available in the dispensary. The SOPs had not been signed by the team members, but they confirmed that they had read through them when the new owners took over. The SOPs covered a range of areas such as the Responsible Pharmacist (RP) and controlled drug (CD) procedures.

Dispensing mistakes that were identified before a medicine was handed out (known as near misses) were recorded on a log in the dispensary. The records seen did not include a reason as to why the near miss had happened or what actions had been taken as a result, which could make them less useful. The RP was a regular relief pharmacist and had not worked at the pharmacy long. She said was planning to review the near misses at the end of each month and then discuss any patterns or trends with the team. She gave an example of a mistake that had happened where tablet had been dispensed instead of capsules, and as a result the different forms had been moved to separate parts of the dispensary. Dispensing errors, where a dispensing mistake had happened and the medicine had been handed out, were recorded on designated incident forms. The RP was also aware of how to report incidents on the National Reporting and Learning System.

The medicines counter assistant (MCA) was able to explain what she could and could not do if the pharmacist had not turned up in the morning. And she could describe what she would do if a person requested a medicine which could be abused.

There was a sign in the shop area which explained to people how they could make a complaint or provide feedback. The dispenser was not aware of any recent complaints and there was a complaints procedure for staff to follow. The pharmacy had current indemnity insurance.

The right RP notice was displayed, and the RP record largely complied with requirements. Some records about emergency supplies did not have the nature of the emergency recorded. And a few private prescription records did not contain the prescriber's details. The CD registers seen had been filled in correctly, and the CD running balances were usually checked regularly. A random check of a CD showed that the recorded balance matched the quantity in stock. Team members said that the pharmacy only supplied unlicensed medicines rarely, and they could not remember the last time one had been dispensed.

Confidential waste was bagged and sent off to head office for disposal. No confidential information could be seen from the shop area, and computer screens were turned away from the public. Computers were password protected and most staff had individual smartcards to access the electronic NHS systems. One team member was in the process of applying for their smartcard.

The RP confirmed that she had done safeguarding training and could explain what she would do if she had a concern about a vulnerable person. She knew how to access a list of safeguarding contacts online. Staff had read the safeguarding procedure for children and young people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services safely and effectively and they do the right training for their roles. They get some ongoing training to help them keep their knowledge and skills up to date. They feel comfortable about raising any concerns, and able to take professional decisions.

Inspector's evidence

During the inspection there was the RP, a trained MCA, and a trained dispenser. There was another team member who had been working as a dispenser for almost three months but had not yet completed an accredited course. The team member explained that they had almost finished the course with their previous employer. The need to register the team member on an accredited course within three months of starting was discussed with the RP. The team was up to date with its dispensing, and staff were observed communicating effectively with each other and working in an organised way.

The MCA showed how she could access the company intranet on the till point, and this had updates about new products and training packages. The dispenser said that the company sent updates about new products and services to the pharmacy. Team members felt comfortable about raising any concerns, and the RP felt able to take professional decisions. Staff were set some targets including the number of items and the New Medicine Service, but they did not feel under any undue pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy’s services and they are kept secure. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean and generally tidy and there was good lighting throughout. Storage space was limited but had been used well, and there was enough clear workspace to dispense. The sink tap in the dispensary was faulty, and the RP said she had reported this to maintenance a few days ago. In the meantime, staff were using the sink in the nearby staff kitchen if water was needed to prepare medicines such as antibiotics. The consultation room provided an adequate level of soundproofing so that people could have conversations in there at a normal level of volume and not be overheard. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and manages them well. It obtains its medicines from reputable sources and stores them properly. Team members take the right action in response to safety alerts to help ensure that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was a small step leading into the pharmacy from outside, and there was a handle on the wall to assist people coming in. Team members had a clear view of the front door from the counter and said that they went and helped people if needed. There was a large open space in the shop area which would help people with wheelchairs and pushchairs manoeuvre. The pharmacy computers could generate large-print labels, and staff had access to online translation software. Some team members were also multilingual.

Dispensing baskets were used to keep different people's medicine separate. The RP showed how prescriptions for higher-risk medicines were highlighted. But one example of these prescriptions found on the shelf had not been highlighted and this was discussed with the RP. Prescriptions for CDs had the date the prescription was valid until printed on the bag label. Team members were aware of the recent guidance about sodium valproate and were not aware of any people who were currently in the at-risk group.

Dispensed multi-compartment compliance packs were labelled with a description of the medicines inside and were supplied with patient information leaflets. The person's GP would assess people to see if they needed the packs. Some packs had a label on them which said they had been accuracy checked but not clinically checked. The RP explained that this was for when the packs were assembled from previous records, before the prescription had arrived in. And team members said that there had been difficulties in getting some people's prescriptions in time. The potential risks involved in doing this were discussed with the RP. The labels were also seen on packs which were ready to be supplied to people, which could potentially cause confusion as people may not think that their medicines had been properly checked.

The pharmacy administered seasonal flu vaccinations, but it was not currently providing this service If a person wanted a travel vaccine, the RP explained that the person applied for one online. And then a prescription was sent electronically to the pharmacy and the vaccine was administered. The RP had not yet administered any travel vaccinations, but was unsure if other pharmacists attending the branch had administered any.

The pharmacy obtained its medicines from licensed suppliers and stored them tidily. CDs were kept in a secure location. Team members were unable to find any records about the date-checking of stock but explained that the stock had all been checked during the stocktake a few months ago. No out-of-date medicines were found during a random check of dispensary medicines. The RP said that a date-checking record would be kept in the future. Fridge temperatures were usually checked daily, and the temperature records seen were within the appropriate range. Bulk liquids were marked with the date of opening to help staff know if they were still suitable to use. Medicine for destruction were kept

separate from current stock and placed into designated destruction bins.

The pharmacy received drug alerts and recalls via email. Team members described the action they took in response to them. But a record of the action taken was not always recorded, which could make it harder for the pharmacy to show what it had done.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services and it maintains it appropriately. It uses its equipment to help protect people's personal information.

Inspector's evidence

There were clean calibrated glass measures for use with liquids. The blood pressure meter had been replaced when the new owner took over and was only a few months old, but the RP was not certain how often it was replaced or recalibrated. There was clean tablet and capsule counting equipment, and a separate tablet counting triangle was used for cytotoxic medicines to avoid cross-contamination. The phone was cordless and could be moved to a quieter place in the pharmacy to help protect people's personal information.

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.