General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kamsons Pharmacy, The New Medical Centre, Cattershall Road, GODALMING, Surrey, GU7 1NJ

Pharmacy reference: 1092494

Type of pharmacy: Community

Date of inspection: 10/03/2023

Pharmacy context

This NHS community pharmacy is set next door to a medical centre on the outskirts of Godalming. The pharmacy is part of a small chain of pharmacies. It opens six days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy supplies multi-compartment compliance packs (compliance packs) to people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. Its team can check a person's blood pressure. And people can get their flu vaccination (jab) and travel vaccinations at the pharmacy too.

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

The pharmacy manages its risks appropriately. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy review the mistakes they make to try and stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had considered the risks of coronavirus. And, as a result, it had put a plastic screen on its counter to try and stop the spread of the virus. The pharmacy team had the personal protective equipment it needed. And hand sanitising gel was available too. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed by a team at the pharmacy's head office. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to say they understood them and would follow them. The pharmacy generally stored its pharmaceutical stock in alphabetical order. And its team had highlighted a few medicines which were similar in some way, such as those that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being selected. The team members who were responsible for making up people's prescriptions kept the dispensing workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by the responsible pharmacist (RP). The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person and those which weren't. Members of the pharmacy team discussed, recorded and reviewed the mistakes they made to learn from them and reduce the chances of them happening again. But they needed to review the records of the mistakes they have made since the beginning of the year to spot any patterns and help them strengthen their dispensing process further.

The pharmacy had a notice that told people who the RP was at that time. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. Some people have shared their experiences of using the pharmacy and its services online. The pharmacy had a complaints procedure. It had a notice which asked people to share their views and suggestions about how the pharmacy could do things better. And, for example, the pharmacy team tried to keep a person's preferred make of a prescription medicine in stock when it was asked to do so. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. It had an electronic controlled drug (CD) register. And the stock levels recorded in the register were checked more often than the SOPs asked them to be. But the address from where a CD came from was incomplete in the sample of entries seen. The pharmacy had an electronic record to show which pharmacist was the RP and when. It kept records for the supplies of the unlicensed medicinal products it made. But the date an unlicensed medicinal product was received

at the pharmacy wasn't always recorded. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But occasionally the reason for making a supply of a prescription-only medicine to a person in an emergency wasn't recorded properly. And the details of the prescriber were sometimes incomplete or incorrect in the sample of the private prescription records seen.

People using the pharmacy couldn't see other people's personal information. And the company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy displayed a notice that told people how the company gathered, used and shared their personal information. It had an information governance policy. And its team needed to sign a confidentiality agreement and complete training on data security. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always obliterated or removed from the unwanted medicines people returned to it before being disposed of. The pharmacy had safeguarding procedures. And the RP had completed level 2 safeguarding training. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has the people it needs in its team to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy team consisted of a pharmacist manager (the RP), two dispensing assistants, three trainee dispensing assistants, a medicines counter assistant and a delivery driver. The RP, the dispensing assistants and a trainee dispensing assistant were working at the time of the inspection. The pharmacy relied upon its team, team members from another branch or locum pharmacists to cover absences. Members of the pharmacy team were up to date with their workload. They worked well together and helped each other so people were served quickly, and prescriptions could be dispensed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist. People who worked at the pharmacy needed to undertake accredited training relevant to their roles after completing a probationary period. Members of the pharmacy team discussed their performance and development needs with their manager when they could. They could share learning from the mistakes they made and were usually kept up to date during one-to-one discussions or ad hoc team meetings. They were encouraged to complete training when they could. And they could train in their own time if they wanted to. Members of the pharmacy team didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led to changes to the way they stored and found people's prescriptions.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate and secure environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was air-conditioned, bright and secure. And its public-facing area was adequately presented. But there were some damp patches on the walls in the kitchenette and the toilet which required attention. The pharmacy had the workbench and storage space it needed for its current workload. It had a consulting room for the services it offered that required one and if someone needed to speak to a team member in private. People's conversations in the consulting room couldn't be overheard outside of it. The consulting room couldn't be locked. So, the pharmacy team needed to make sure its contents were kept secure when it wasn't being used. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water. Members of the pharmacy team were responsible for keeping the premises clean and tidy. And they wiped and disinfected the surfaces they and other people touched.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are safe and effective. And its team is friendly and helps people access the services they need. Members of the pharmacy team generally dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources. And it usually stores them appropriately and securely.

Inspector's evidence

The pharmacy didn't have an automated door. But its entrance was level with the outside pavement. And members of the pharmacy team remained alert to make sure they could help people who couldn't open the door easily, such as people with pushchairs or wheelchairs, access the building. The pharmacy had a notice that told people when it was open. It had a few leaflets that told people about some of the services it delivered. And it had a small seating area for people to use when they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses. Members of the pharmacy team were friendly. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery. And people were asked to sign an electronic delivery record to say they had received their medicines safely. The pharmacy had the anaphylaxis resources it needed for its vaccination services. And it had a patient group direction for the administration of flu jabs. The RP was appropriately trained to vaccinate people. And they checked that the correct vaccine had been selected by one of the pharmacy team before they administered it. The pharmacy kept a record for each vaccination it made. This included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And its team assessed whether a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. It provided a brief description of each medicine contained within the compliance packs. And patient information leaflets were usually supplied. So, people had the information they needed to make sure they took their medicines safely. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. It used reminder stickers to alert the team when these items needed to be added or if extra counselling was needed. And assembled CD prescriptions awaiting collection were generally marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And the pharmacy had the resources it needed when its team dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in an appropriate pharmaceutical waste bin. The pharmacy team recorded the destruction of the CDs that people returned to it. But a patient-returned CD was found in the pharmaceutical waste bin. This was removed and quarantined during the inspection. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And a team member described the actions they took and demonstrated what records they made when a drug alert was received.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's personal information is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team generally checked and recorded the refrigerator's maximum and minimum temperatures. Members of the pharmacy team could check a person's blood pressure when asked. And the monitor they used to do this was recently changed. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy put its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they weren't working.

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.