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: 12/08/2022

Pharmacy context

The pharmacy is within a health centre in a mixed commercial and residential area in Luton in Bedfordshire. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. Services include prescription delivery, new medicines (NMS), prescribing service, community pharmacist consultation service (CPCS), travel clinic medicines and seasonal flu vaccinations.

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. And it has suitable procedures in place to make sure its team members know how to work safely. The pharmacy makes sure it identifies and manages the risks so it can show it is providing its services safely. Members of the team generally keep the records they need to up to date so they can show the pharmacy is supplying its services safely. They protect people's private information, and they are appropriately trained in how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. The responsible pharmacist (RP) explained that medicines involved in incidents, or were similar in some way, such as atenolol and allopurinol or amitriptyline and amlodipine were generally separated from each other in the dispensary. Methotrexate tablets were all stored in one place because of being high-risk medicines. The pharmacy had a complaints procedure. And it asked people for feedback via 'Share your experience' for their views and suggestions on how it could do things better.

The pharmacy team separated prescriptions into those which were delivered and those which were collected. Delivery prescriptions were dispensed, checked and bagged at a designated bench in the dispensary. And sorted by postcode for delivery. The collection prescriptions were processed at another bench in the dispensary. Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. Interactions between medicines prescribed for the same person were shown to the RP. Any interventions such as contacting the prescriber were recorded on the counselling notes section on the pharmacy computer. And assembled prescriptions were not handed out or delivered until they were clinically and accuracy checked by the RP. The pharmacy had a process for dealing with outstanding medicines.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these had been reviewed since the last inspection. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. They knew what they could and could not do, what they were responsible for and when they might seek help. A team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines liable to misuse to a pharmacist.

The pharmacy had risk-assessed the impact of COVID-19 upon its services and the people who used it. They had personal protective equipment if needed to help reduce the risks associated with the virus. And they washed their hands regularly and used hand sanitising gel when they needed to. Team members wiped the pharmacy surfaces down regularly during the day. The pharmacy had completed a current physical risk assessment on the premises. And there was a folder of audits the team had

completed such as thalidomide pharmacy audit 2019 and handwashing audit. And audits to monitor people taking valproate or anti-coagulant medication.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy displayed a notice that told people who was the RP and it kept a record to show which pharmacist was the RP and when. The pharmacy had an electronic controlled drug (CD) register and there was an audit trail to show who made the entries in the CD registers. The RP maintained a record of uncollected methadone instalments. The balance of each CD was checked regularly. A random check of supply entries for methadone matched what was prescribed. And the actual stock of another CD matched what was recorded. The pharmacy placed dispensed CDs in clear plastic bags so they could be checked more easily prior to handing them out. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. It recorded the supplies it made against private prescriptions. And these generally were in order. But the name and address of the prescriber were sometimes incorrectly recorded.

The pharmacy team had trained in general data protection regulation (GDPR). The pharmacy displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. A member of the team described how they tried to make sure people's personal information could not be seen by other people and was disposed of securely. And team members had signed confidentiality agreements and used their own NHS smartcards. The pharmacy team had undertaken safeguarding training and could refer to the NHS App for safeguarding. The RP had completed a level 2 safeguarding training course. 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's team members work effectively together to manage their workload and deliver their services safely. The pharmacy supports them in completing appropriate training and they understand their roles and responsibilities.

Inspector's evidence

The pharmacy team consisted of one full-time pharmacist (the RP), a full-time trainee pharmacist, three full-time dispensing assistants (DA), one full-time and one part-time medicines counter assistants (MCA) and two part-time delivery drivers. The pharmacy's head office provided a pre-registration training programme for the trainee pharmacist which was supervised by the RP. The trainee pharmacist attended training days and was allocated regular protected learning time. Other team members had completed accredited training or were due to be enrolled on the training on completion of their probationary period as new recruits. Both the delivery persons had undertaken training such as protecting people's private information when they delivered medicines to people's homes. The pharmacy's head office sent training topics on a regular basis to keep the team's skills and knowledge up to date. Topics included those required by the pharmacy quality scheme (PQS) and provision of pharmacy services. There were training records for each member of the team and the RP conducted annual performance reviews to monitor and identify training needs.

Members of the team worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an over-the-counter (OTC) sales SOP which its team needed to follow. This described the questions the team members needed to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. The RP organised regular team meetings and team members were in a WhatsApp to share any information. And the team referred to a white board which the RP kept up to date with information and messages for the team such as daily tasks to be completed and what time everybody could take a break to ensure there were enough team members to support the RP. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, bright and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe and people's private information is protected.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. And there were two wide level entrances. There were measures in place to make sure the pharmacy and its team did not get too hot. The pharmacy had a spacious retail area, a counter, a large dispensary and storage space. The pharmacy’s consulting room was signposted and locked when not in use. People could have a private conversation with a team member. There was a chaperone policy and health related information displayed. The dispensary had large, clear workbenches available. And floor areas were clear. The pharmacy had a clean sink and lavatory facilities. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy. The pharmacy’s website was clearly set out and easy to navigate by members of the public.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. It displays information about the healthcare services it offers and it makes it easy for people with different needs to access them. The pharmacy obtains its medicines stock from reputable suppliers and stores it securely at the right temperature, so it is safe to supply. Team members know what to do in response to alerts and product recalls and they keep records of any medicines or devices returned to the suppliers.

Inspector's evidence

The pharmacy had wide double doors. And its entrances were level with the external floor. This made it easier for people who found it difficult to climb stairs, such as someone who used a wheelchair, to enter the building. And the pharmacy team tried to make sure these people could use the pharmacy's services. The pharmacy had a notice that told people when it was open and the other services the pharmacy offered. The pharmacy had a seating for people to use if they wanted to wait. Members of the pharmacy team were helpful. They could understand Urdu and Punjabi but the MCA demonstrated Google Translate through the till system. And they signposted people to another provider if a service was not available at the pharmacy such as sexual health. They referred to the NHS directory of services.

People could access services via the website www.kamsons.co.uk and the pharmacy displayed a leaflet explaining which services were available. The pharmacy provided people with travel clinic medicines including vaccinations and malaria prophylaxis. People could complete a questionnaire regarding their travel arrangements or ailment and an independent prescriber could issue a prescription for the vaccines or medicines if appropriate and email it to the pharmacy. Upon completion of vaccinations, the person was issued a vaccination certificate. The pharmacy team received referrals for treatment through the community pharmacist consultation service (CPCS) via PharmOutcomes or NHS email. For the new medicines service, the RP had an initial conversation with the person about how to use their new medicine in the best way. And then followed the person up by phone to monitor how they were benefitting from taking the medicine. The team described dealing with an adverse event or system failure so they had torches in case there was no light, and they could direct people and their prescriptions to a nearby branch.

The pharmacy provided a delivery service to people who could not attend its premises in person. They recorded the delivery schedule on the Prodelivery App and they could track the location of the driver and the package. So there was an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The pharmacy did not routinely prepare multi-compartment compliance aids, but the service was provided by a nearby branch. Members of the pharmacy team initialled dispensing labels so they could identify which of them prepared a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added. They supplied information cards for high-risk medicines, and they were aware of the valproate pregnancy prevention programme. They knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. The dispensary was very tidy. The pharmacy team checked the expiry dates of medicines a few times a year. And it recorded when it had done a date-check. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs, which were not exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people returned to it. Waste medicines were kept separate from stock and were placed in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy had screens and hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had clean glass measures for use with liquids, and some were used only with certain liquids. The pharmacy team had access to up-to-date reference sources. The pharmacy's electrical equipment was PAT tested. The pharmacy had a new blood pressure monitor for the blood pressure monitoring service. And it had a sharps bin to dispose of vaccination sharps. The anaphylaxis kit was in date and the nearest defibrillator was in the health centre. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerator which were recorded. The pharmacy collected confidential wastepaper for safe disposal. It 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 positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure they used their own NHS smartcards when they were 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.