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: 19/02/2024

Pharmacy context

The pharmacy is adjacent to two large health centres near the centre of Bradford. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide the NHS Pharmacy First service. And other services including seasonal flu vaccinations and the Pharmacy Contraception Service. The pharmacy also delivers medicines to people's homes.

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 comprehensively review the mistakes they make. And they use this information to help make and sustain effective changes to help improve the safety of their services.
2. Staff	Standards met	2.4	Good practice	Pharmacy team members confidently discuss their learning and development needs together. And they make effective changes to address their needs and to achieve common goals.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	Pharmacy team members use various tools effectively to help identify and manage the risks of people taking higher-risk medicines. And they consistently make good records to help improve people's care.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy effectively identifies and manages risks with its services. Pharmacy team members comprehensively record and review their mistakes to help them learn. And they make effective changes to help improve safety. Team members understand their role in protecting vulnerable people. And they suitably protect people's confidential information.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage risks. The company had reviewed the SOPs in 2023 and were due to review them again in 2025. Team members explained that new and updated SOPs were brought to their attention by the pharmacist, and they read them as soon as possible. Pharmacy team members had signed to confirm they had read and understood the SOPs. But they did not always record that they had read and understood the most up-to-date SOPs. The records available showed that most team members had last signed to confirm their understanding in 2022. But they gave their assurances that they had read the SOPs since they had last been reviewed in 2023. The pharmacist also explained that team members may be asked to read relevant SOPs again after an error or incident. But they did not always record these refreshers.

The pharmacy had recently started providing the NHS Pharmacy First service for people. Pharmacy team members were able to provide treatment for seven minor ailments via NHS patient group directions (PGDs). And signed copies of the relevant documents were available. The pharmacy had considered the risks of delivering the service to people. The pharmacist explained how they assessed various risks, such as the suitability of the layout of the pharmacy's consultation room, ensuring that people had completed the necessary training, the availability of the necessary equipment, and having the correct SOPs in place. Some of these assessments had not been written down to help team members manage emerging risks on an ongoing basis.

Pharmacy team members read a monthly bulletin from the company's head office, which communicated professional issues and learning from across the organisation. The bulletin provided best practice guidance on various topics and case studies based on real incidents that had occurred. It detailed how pharmacy team members could learn from these. A recent example of a case study highlighted the importance of responding appropriately in an emergency. This had prompted the team to have further discussion about various aspects, including who was trained to administer first aid, how they would manage other people's needs if the pharmacist was dealing with the emergency, and refreshing their knowledge about local pharmacies where they could signpost people to for pharmacy services

Pharmacy team members highlighted and recorded near miss errors they made when dispensing. There were documented procedures to help them do this effectively. Team members explained how they discussed their errors and why they might have happened. And they generally captured this key information to help inform the analysis process. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. The records available were comprehensive and provided detailed information about the error, team discussions and the changes team members had made to improve safety. The pharmacist analysed all data collected about errors

each month to help identify patterns and compiled the information into a comprehensive report for the team to read. Team members discussed the patterns found at a monthly meeting and implemented changes to help prevent the same or similar errors happening again. There were several examples available of the changes team members had made in response to errors. These included organising their dispensing processes more effectively to help prevent mistakes when preparing medicines in multi-compartment compliance packs. And implementing new systems to manage distractions to help prevent them contributing to people making errors. They were able to demonstrate the success of their changes by continuing to analyse error data. And the data showed a significant reduction in the number of errors being caused by distractions.

The pharmacy had a documented procedure in place for handling complaints and feedback from people. Pharmacy team members explained feedback was usually collected verbally and by asking people to complete customer surveys online. And there was information for people in the retail area about how to do this. In response to feedback, the pharmacy had recently provided more chairs for people to use while waiting.

The pharmacy had current professional indemnity insurance. It kept accurate controlled drug (CD) registers electronically, with running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity every two weeks. The pharmacy maintained a register of CDs returned by people for destruction, and this was correctly completed. It maintained a responsible pharmacist record, which was also up to date. The pharmacist displayed their responsible pharmacist notice so they could be identified. Pharmacy team members monitored and recorded fridge temperatures daily. And they accurately recorded private prescriptions and emergency supplies.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags, which were collected periodically and returned to the company’s head office for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage people's sensitive information. Team members explained how important it was to protect people's privacy and how they would protect confidentiality. And they completed mandatory training on this each year. A pharmacy team member gave some examples of signs that would raise their concerns about the welfare of vulnerable children and adults. And how they would refer to the pharmacist. The pharmacy had procedures for dealing with safeguarding concerns. Pharmacy team members completed mandatory safeguarding training every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are suitably qualified for their roles and the services they provide. They confidently discuss their learning and development needs together. And they make effective changes to address their needs and achieve common goals. Team members complete ongoing training to keep their knowledge and skills up to date. They manage the workload well and feel comfortable raising and discussing concerns.

Inspector's evidence

During the inspection, the pharmacy was staffed by a pharmacist manager, four qualified dispensers, a trainee dispenser, and a delivery driver. One of the qualified dispensers was also accredited to perform the final accuracy check of prescriptions. Team members managed the workload well during the inspection. They completed mandatory e-learning modules regularly, which covered mandatory compliance training such as information governance and safeguarding. But also covered more clinical topics, such as sepsis and dementia awareness. The team had recently completed training about emergency contraception, to help team members better understand the options they could recommend and the benefits and limitations of each treatment option. Team members explained how the training had prompted discussions between them about sexual and reproductive health to help deepen their understanding.

The pharmacy had an appraisal process for pharmacy team members. They had a meeting every year with their manager to discuss their performance, who set objectives to address any learning needs identified. One example of an objective set followed a team member identifying their lack of confidence responding to queries about medicines prepared in multi-compartment compliance packs. And they felt this was because they did not often manage and prepare packs for people. So, the team provided them with more opportunities in this area to help improve their confidence. Team members explained they raised any learning needs informally with the pharmacist, who supported them to access the right resources to help improve their knowledge. The pharmacist had recently trained team members about the NHS Pharmacy First service and provided them with reference materials to help them know when to refer people to the pharmacist to access the service. They had also included training to help team members engage with people in conversations about their health and wellbeing.

A team member explained how they would raise professional concerns with the pharmacist or their area manager. They felt comfortable raising concerns and making suggestions to help improve the pharmacy's ways of working. They were confident that their concerns and suggestions would be considered, and changes made where they were needed. Team members explained they often discussed improvements with each other and were given the freedom to implement their agreed suggestions. One recent example had been a discussion about how team members felt they were losing confidence and knowledge working in different areas of the pharmacy. They identified that this was because team members took responsibility for certain tasks, which left little opportunity for others to perform these tasks as well. Following their discussion, they had implemented a task rota. Each week, team members were assigned to tasks. The following week, they rotated to a different task. They explained their change meant they now felt more confident working in different areas of the pharmacy business. And better able to maintain their services when people were absent.

As part of the discussion above, team members had also identified their apprehension about providing information and advice to people over the counter, after one of their colleagues who did this most often reduced their working hours. The team discussed the gaps in their knowledge and the pharmacist provided them with resources to use to help improve their skills. One of these was a table of dangerous symptoms that people might present with that required immediate referral to the pharmacist. Another was a textbook providing in-depth information about common ailments. Team members explained this was particularly useful when assessing dermatological conditions.

The pharmacy had a whistleblowing policy, and pharmacy team members knew how to access this. The team communicated openly and worked well together during the inspection. Team members were asked to achieved targets in various areas of the business, for example relating to the number of prescription items dispensed, and the number of professional services delivered. Team members explained they felt comfortable achieving the targets set. They explained their strategies for achieving their targets safely.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy’s floors and passageways were generally free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a consultation room, which was clearly signposted, and pharmacy team members used the room to deliver services and have private conversations with people.

There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a toilet with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy kept heating and lighting to acceptable levels. Overall, the pharmacy's appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are accessible to people. It operates and provides its services safely. And team members are good at using the pharmacy's systems to help ensure people receive appropriate advice and information about their medicines. The pharmacy sources its medicines appropriately. And it stores and manages its medicines properly.

Inspector's evidence

The pharmacy had level access from the car park through automatic doors. Team members explained how they would communicate in writing with people with a hearing impairment. They could provide large-print labels and instruction sheets to help people with a visual impairment access services.

The health centre adjacent to the pharmacy provided people with a specialist dermatology clinic each week. This meant the pharmacy often received prescriptions for isotretinoin, which is a higher-risk medicines requiring careful management when used by people who may become pregnant. To help people manage these risks, pharmacy team members had completed learning specifically about the risks of isotretinoin and had created a laminated checklist which they kept with the medicine on the shelves. The checklist prompted team members to check they had various key pieces of information before supplying the medicine. Team members spoke to each person about their medicine to make sure they were comfortable about how to use it safely. They recorded these key pieces of information on the person’s electronic medication record (PMR), to refer to later.

Pharmacy team members used a similar process to help people manage the risks of taking valproate. The pharmacist counselled people, and they checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if they were on a pregnancy prevention programme and taking regular effective contraception. The pharmacy had stock of some information materials to give to people to help them understand the risks of taking valproate. And they recorded when they gave advice. Team members were aware of the requirements to supply valproate to people in the manufacturers original pack. They had also removed any split packs of valproate from the shelves to help prevent incomplete packs being supplied by mistake. A recently completed audit of people taking oral anticoagulants had prompted team members to attach warning stickers to the shelves where warfarin and apixaban were kept to act as an alert. They had created an alert card that they placed in a basket with any warfarin they dispensed. The card prompted team members to ask people for key information, such as the results of their latest warfarin blood test and whether they were clear about the correct dose to take. And to record this information on their PMR.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. And they signed a quadrant printed on the prescription. This was to maintain an audit trail of the people involved in the dispensing process. They used baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy supplied medicines for people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Team members included descriptions on the packs of what the medicines looked like, so they could be identified in the pack. And 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 person’s master record sheet. This was

a record of all their medicines and the times of administration. They also recorded this information on their PMR. And team members recorded any conversations in an interventions tracker, to help them resolve future queries more efficiently.

The pharmacy used its electronic PMR system to record and monitor any interventions the team made about prescriptions. This helped it monitor outcomes received and what the outcomes were. For example, team members submitted prescription change requests to the GP in writing, and they attached the letter as an intervention record to the persons PMR. They monitored the progress of interventions each day, and could easily see the record when dispensing medicines. Team members also used the interventions system to record conversations about people's medicines, to help easily resolve future queries.

The pharmacy delivered medicines to people via a delivery driver. The pharmacy recorded its deliveries. And pharmacy team members highlighted bags containing CDs to the driver. The delivery driver left a card through the letterbox if the person was not at home when they attempted a delivery, asking people to contact the pharmacy. The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day and recorded their findings. The temperature records seen were within acceptable limits. Team members recorded weekly checks of medicine expiry dates. They completed checks in various areas of the pharmacy on a rolling cycle. This meant they checked all stock medicines every three months. They highlighted any short-dated items up to twelve months before their expiry. And they removed expiring items during the check before they were due to expire. Pharmacy team members responded to any alerts or recalls they received about medicines from manufacturers and other agencies. They removed any affected medicines from the shelves, and they recorded the actions they had taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains its equipment properly, so it is safe to use. And pharmacy team members manage and use the equipment in ways that protect people’s confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. It had reference resources available, including the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected.

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.