General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kamsons Pharmacy, 1A Lewes Road, BRIGHTON, East Sussex, BN2 3HP

Pharmacy reference: 1107827

Type of pharmacy: Community

Date of inspection: 03/01/2024

Pharmacy context

This is a community pharmacy on a busy main road in Brighton. It is in the same building as a medical centre and not far from a university. It mainly dispenses NHS prescriptions and offers flu vaccinations (when in season) and travel vaccinations. It supplies medication in multi-compartment compliance packs to people who need this additional level of support. And these packs are usually assembled by the pharmacy's offsite hub. The pharmacy also provides the New Medicine Service (NMS) and a supervised adminstration service.

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 identifies and manages the risks associated with its services. Team members know about their own roles and responsibilities. People using the pharmacy can provide feedback about its services. The pharmacy generally keeps the records it needs to by law, and it protects people's personal information well. Team members know how to protect the welfare of vulnerable people. They record and review any dispensing mistakes and use this information to help make the pharmacy's services safer.

Inspector's evidence

The pharmacy had a printed set of standard operating procedures (SOPs). There were spaces for team members to sign the SOPs when they had read them, and no signatures were found. However, team members confirmed that they had read through the SOPs, and some staff had transferred from the company's other branches and said that they had signed them at their previous branch.

Near misses, where a dispensing mistake was identified as part of the dispensing process, were recorded on a paper log on an ongoing basis. The responsible pharmacist (RP) explained how she reviewed the near misses at the end of each month and talked with the team about any patterns or trends she found. The RP gave examples of medicines which had been moved to separate shelves or where shelves had been highlighted as a result of previous reviews. For example, she showed that ramipril capsules had been moved to a separate shelf to ramipril tablets. She explained how she would record any dispensing errors, where a dispensing mistake had reached a person. This included making a record and investigating the error, and a copy of the form was sent to the pharmacy's head office. The RP gave an example of when she had talked with the team to highlight that some packs of zopiclone looked very similar to packs of diazepam.

The trainee dispenser was able to describe what she could and could not do if the RP had not turned up in the morning. And the SOPs outlined what to do in this situation. A team member explained that medicines such as codeine linctus and promethazine elixir were not sold over the counter and were only supplied on prescription. And they knew how to respond to requests for medicines which were liable to abuse. During the inspection, staff were observed working in an organised way and communicating effectively with their colleagues.

There was a sign in the public area explaining to people how they could raise a concern or provide feedback. And there was a complaint procedure that team members could refer to. The RP described how the pharmacy was now using a new system for medicine deliveries to people's homes, where deliveries were prioritised so that they were ready to go out on time. And this had resulted in positive feedback from people.

The right RP notice was displayed to the public, and the RP records seen complied with requirements. The pharmacy had current indemnity insurance. Records seen about emergency supplies and supplies of unlicensed medicines had the right information recorded. Some of the records about private prescriptions dispensed did not include the name of the prescriber, and this was highlighted to the RP. Controlled drug (CD) registers were electronic, and the CD running balances were checked regularly. A random check of a CD found that the physical stock matched the recorded balance.

No confidential information was visible from the public area of the pharmacy. Confidential waste was separated from general waste and sent offsite for disposal. Computers were password protected and the screens positioned so that people using the pharmacy could not see information on them. Most staff had individual smartcards to access the electronic NHS systems, and one team member was in the process of applying for one.

The RP confirmed that she had completed safeguarding training and could describe what she would do if she had any concerns about a vulnerable person. She was aware of the online resources that were available and the NHS safeguarding application. She said that the delivery drivers were aware of the need to report any safeguarding concerns back to the pharmacy and gave an example of an incident that had occurred that had been handled appropriately. Some team members reported that they had completed safeguarding training, and there was a safeguarding SOP for staff to refer to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services safely and they feel comfortable about making suggestions or raising any concerns. They are able to take professional decisions to help keep people safe. Staff do the right training for their roles. And they do some ongoing training to help keep their knowledge and skills up to date.

Inspector's evidence

During the inspection there was the RP, a trained dispenser, two trainee dispensers, and a pharmacy student who was working mainly on the counter and had also completed the dispenser and counter courses. There was another member of staff who had worked at the pharmacy for around six months. The RP understood that they had been registered on the dispenser course, but this was not clear during the inspection. Following the inspection, the company's Professional Development Manager provided evidence that the member of staff had been registered on a dispenser course. Team members were observed referring queries to the RP as appropriate, and the RP was seen counselling several people coming in. The pharmacy was generally up to date with its dispensing and staff were seen to be able to dispense for people walking in with prescriptions relatively quickly. However, there were many baskets of dispensed medicines which were awaiting the final check on the centre island counter which were from the busy Christmas period.

Staff felt comfortable about raising any concerns or making suggestions to improve how the pharmacy worked. Team members did ongoing training on an ad hoc basis and received a regular newsletter from the company and information from wholesalers. Staff from head office also came in to brief the team about new services or systems, and team members gave an example of the pharmacy's new digital tracker for deliveries. A trainee dispenser said that team members undertaking accredited training courses were given protected time to complete them. Staff were set some targets such as the number of prescription items and NMS, but these did not impact on people's care or the RP's ability to take professional decisions.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was of an adequate size and it was kept clean. Some of the workbenches had piles of baskets containing dispensed prescriptions awaiting the final check, but there was still enough space to dispense safely. Lighting was good throughout, and the room temperature was suitable for storing medicines.

There were two consultation rooms which were suitable for private conversations. As found on the previous inspection, one room had cupboards which contained some confidential information. This was discussed with the RP who gave an assurance that the cupboards would be kept locked in future. There were keys available for the locks. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is providing its services safely and effectively. It gets its medicines from reputable sources and largely stores them appropriately. It takes the right action in response to safety alerts to help ensure that people get medicines and medicine devices that are safe to use. It uses its computer system effectively to help team members easily locate dispensed items.

Inspector's evidence

There was step free access into the pharmacy from the street via an automatic door, and also access directly from the adjoining medical centre. The shop area had a large open space which helped people with wheelchairs and pushchairs manoeuvre. The RP described how she had undertaken training to be able to provide a contraceptive and sexually transmitted disease testing service. She said that she had done this to increase local access to these services.

Colour-coded baskets were used to help keep different people's medicines separate. Although there were many baskets containing medicines and prescriptions, these were generally well organised and kept tidy. The RP used a specific area of the dispensary for checking dispensed prescriptions.

Multi-compartment compliance packs were usually assembled by the company's central dispensing hub before being supplied by the pharmacy. The RP said that people were assessed to see if they needed the packs by discussions between the person, the GP surgery, and the pharmacy. The packs had an audit trail to indicate who had dispensed and checked them and were labelled with a description of the medicines inside. Patient information leaflets were not usually supplied with the packs. The packs had a QR code on them, which when scanned directed people to the EMC website, but not to the page for the specific medicines. A small number of packs were assembled in the pharmacy, and this was usually done where it was a smaller amount of medicines or if a person required the packs more frequently. These packs did not have a QR code on them, and patient information leaflets were not routinely supplied. This could make it harder for people and their carers to have up to date information about how to take the medicines safely.

The pharmacy was providing flu vaccinations and copies of the relevant National Protocol and Patient Group Directions were available in the dispensary. People could book appointments for flu vaccinations online. The RP described the training she had undertaken about providing vaccinations, which included online and face-to-face training. 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. A printed copy of the prescription, together with the batch number and expiry date of the vaccine administered was retained in the pharmacy.

The RP said that prescriptions for higher-risk medicines such as warfarin or lithium, and CDs were highlighted and showed the stickers that would be used. No examples of prescriptions for higher-risk medicines were found on the shelves. Bags of dispensed medicines containing CDs or fridge items were marked with a sticker. Team members were aware of the guidance about pregnancy prevention for people taking valproate-containing medicines. And about the more recent guidance about providing the medicine in its original manufacturer's pack. The RP was not aware of any people taking these medicines who were currently in the at-risk group.

The pharmacy had recently started using a new computer system, which included an audit trail where a barcode would be scanned when a bag of dispensed medicines was handed out. The RP showed how the computer system also identified which shelf the bag was on in the dispensary and whether there were any fridge items or CDs requiring safe storage. She demonstrated that the computer also showed when a person had more than one prescription to collect, and it informed the member of staff of the different shelves where the medicines were. This helped reduce the risk of people not collecting all their medicines when they came into the pharmacy. The RP explained that the pharmacy was in the process of setting up email notifications to people when their medicines were ready to collect.

The pharmacy did deliveries of medicines to some people's homes and used drivers shared with other local branches. An electronic audit trail was kept for the deliveries which included when a delivery had been attempted and the person was not at home.

Medicines were obtained from licensed wholesale dealers and specials suppliers. The pharmacy generally kept its medicines in a tidy way. Date-checking records had recently been set up, and each team member had been allocated a section to check. A selection of medicines were checked at random and no date-expired medicines were found in stock. Bulk liquids were marked with the date of opening so that staff knew if they were still suitable to use. Medicines for destruction were kept separate from in-use stock.

Drug alerts and recalls were received via email from several sources. The RP described the action that was taken in response. Some records about recalls received were kept in a folder, but the most recent one was from September 2023. The RP explained that recent recalls had not been applicable to the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had clean glass measures for use with liquids. There was a machine used for measuring liquids for the substance misuse service, and this was calibrated and flushed daily. Periodically, it was cleaned with a specialised solution. Calibration records were available electronically. Tablet counting equipment was clean. The phone was cordless and could be moved to a more private area. There was a separate counter for people to access the needle exchange and supervised administration services, and this helped provide a degree of privacy for people who wanted it.

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.