General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kamsons Pharmacy, 139 Brighton Road, CRAWLEY, West Sussex, RH10 6TE

Pharmacy reference: 1109049

Type of pharmacy: Community

Date of inspection: 19/01/2024

Pharmacy context

This busy NHS community pharmacy is next to a GP surgery in a residential area of Crawley. The pharmacy is part of a 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 provides a substance misuse treatment service. It supplies multi-compartment compliance packs (compliance packs) to a few 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. And people can visit the pharmacy to get their coronavirus booster, flu jab or travel vaccination, or have their blood pressure checked.

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 generally manages its risks appropriately. It has written instructions to help its team members work safely. It largely 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 talk to each other about the mistakes they make to try to 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

People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had some plastic screens on its counter to help reduce the spread of airborne infections such as coronavirus. And hand sanitising gel was also available for people to use. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed regularly by a team based 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. They knew what they could and couldn't do, what they were responsible for and when they might seek help. Their responsibilities were also described within the SOPs. And a notice in the pharmacy told people who the responsible pharmacist (RP) was at that time. 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 the pharmacist. The team members responsible for making up people's prescriptions tried to keep the dispensing and checking 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 by the RP who also initialled the dispensing label. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). Members of the pharmacy team discussed the mistakes they made to learn from them and help them stop the same sort of things happening again. But they could do more to make sure they routinely recorded their near misses to help them spot any patterns in the mistakes they made.

Some people have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. People could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. And, for example, the pharmacy team tried to order a person's preferred make of a prescription medicine when it was asked to do so. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept appropriate records to show which pharmacist was the RP and when. And it had an electronic CD register which was appropriately maintained. But its team could do more to make sure it recorded when it had checked the stock levels in the CD register. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. But occasionally it didn't record when it received and supplied one of these products as well as who it supplied. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its

computer. But the details of the prescriber were incomplete in some of the private prescription records seen. And the team was reminded that it needed to make an appropriate record when a prescription-only medicine (POM) was supplied to a person in emergency including requests for an urgent supply of a medicine through the CPCS. The pharmacy team gave an assurance that these records would be maintained as they should be.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy had an information governance policy. And its team needed to complete training on data security. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. But people's personal details weren't routinely crossed out or removed from the unwanted medicines returned to the pharmacy before being disposed of. The pharmacy had a safeguarding policy. And pharmacy professionals were asked to complete 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 enough people in its team to deliver safe and effective care. Members of the pharmacy team work well together and use their judgement to make decisions about what is right for the people they care for. They know how to raise a concern if they have one. And they can give feedback to help the pharmacy do things better.

Inspector's evidence

The pharmacy had an induction training programme for its team. People who worked at the pharmacy needed to complete mandatory training during their employment. And they were required to undertake accredited training relevant to their roles after completing a probationary period. The pharmacy team consisted of a pharmacist, an accuracy-checking pharmacy technician (ACPT), a trainee pharmacist, a trained dispensing assistant, two trainee dispensing assistants, three medicines counter assistants (MCAs), a counter assistant and two delivery drivers. The pharmacy had three other pharmacy support team members who worked on an occasional basis. But, despite starting at the pharmacy over three months ago, two of them and the counter assistant hadn't completed or started accredited training relevant to their roles. The Area Manager and the Professional Development Manager (PDM) provided an assurance following the inspection that any team member who had worked at the pharmacy for three months or more would be enrolled upon a relevant training course. And the PDM provided evidence that the counter assistant had been enrolled upon a MCA training course. The pharmacy depended upon its team, team members from another branch or locum pharmacists to cover absences. The people working at the pharmacy during the inspection included a relief pharmacist (the RP), the ACPT, the trainee pharmacist, the dispensing assistant, a trainee dispensing assistant, a MCA and the counter assistant. The pharmacy and its team were managed by the regular pharmacist. There had been an increase in the dispensing volume since the last inspection. But the pharmacy team was generally up to date with the workload. Members of the pharmacy team worked well together. They helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. 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. Members of the pharmacy team discussed their development needs with their manager when they could. They were encouraged to ask questions and keep their knowledge up to date by completing training. They were sometimes too busy to train while they were at work. But they could choose to train in their own time. The pharmacy had meetings as well as one-to-one discussions to update its team and share learning. The pharmacy team was comfortable about making suggestions on how to improve the pharmacy and its services. Team members 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 told each other when a person didn't need their medicines, for example, if the person was in hospital.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate 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 tidy. And its public-facing area was adequately presented. But the automatic door wasn’t working properly at the time of the inspection. And a few ceiling tiles were stained or missing as the roof had leaked. The pharmacy team explained that the door was going to be fixed soon and the roof had already been repaired. The pharmacy had two consulting rooms, a counter, a dispensary, a kitchenette, a retail area, a stockroom and a toilet. But it had limited workspace and storage available. And its worksurfaces in the areas that people using its services couldn’t see sometimes became cluttered when it was busy. The pharmacy was scheduled to be refurbished over the coming months. And this meant it would have more storage and workspace to accommodate the increased workload. The consulting rooms were available for services that needed one or if someone needed to speak to a team member in private. But the pharmacy team could do more to make sure their contents were kept secure when they weren’t being used. The pharmacy had the sinks it needed for the services its team delivered. It had a supply of hot and cold water. And its team was responsible for keeping its premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are safe and effective. And it keeps appropriate records for its vaccination service to show that it has given the right vaccine to the right person. The pharmacy gets its medicines from reputable sources. And it usually stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They largely 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.

Inspector's evidence

The pharmacy had some notices that told people about the services it delivered and when it was open. Its entrance was level with the outside pavement. It had a seating area for people to use if they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about it. The pharmacy dealt with CPCS referrals. People benefited from this service 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 and helpful. 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 local delivery service to people who couldn't attend its premises in person. And it kept an electronic record to show the right medicine was delivered to the right person and when. The pharmacy had, until recently, provided coronavirus boosters. And it provided flu jabs too. The vaccinators administered these vaccinations under the relevant national protocols. And a specified registered healthcare professional completed the stages of the national protocol they needed to. The national protocols afforded the pharmacy some flexibility in arranging vaccinators to be on-site to deliver the service if needed. But the appropriate patient group direction could also be used if the vaccination was solely provided by a pharmacist. The pharmacy had the anaphylaxis resources it needed for its vaccination service. And the vaccinators were appropriately trained to vaccinate people. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacy also administered some travel vaccines and supplied a limited range of POMs such as those to treat delay menstruation or to treat erectile dysfunction. People completed a questionnaire, either in the pharmacy or online, which one of the company's pharmacist independent prescribers (PIPs) used to prescribe the appropriate vaccine or medicine. The PIP contacted people direct if they had any queries before prescribing anything. And the pharmacist would check the person's identity and satisfy themselves that the product was safe and appropriate for the person to have before providing it. The pharmacy provided a substance misuse service to a few people. And some of them had to consume their medicine under the supervision of a pharmacist. The pharmacy team asked people using the needle exchange service to return their spent sharps within the proper container and deposit this into a designated waste receptacle. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And these were usually assembled off-site at another pharmacy (the hub) and were returned to the pharmacy for people to collect or to be delivered. But people could choose not to have their prescriptions dispensed at the hub. The pharmacy kept an audit trail of the people who had assembled and checked each compliance pack. An assessment was done to determine

if a person needed a compliance pack. And the suitability for a medicine to be re-packaged was checked. The compliance pack contained a brief description of each medicine contained within it. But patient information leaflets weren't always supplied. And an instruction on the compliance packs asked people to download these or phone the pharmacy to ask for them instead. This meant that people sometimes didn't have the information they needed when they needed it to take their medicines safely. The pharmacy had started to use a nearby pharmacy, under the same ownership as it, to assemble some of its repeat prescriptions for whole packs of medicines. And once assembled these prescriptions were sent back to the pharmacy to be supplied. The pharmacy team was responsible for the accuracy of the data entered into the computer for prescriptions dispensed at the hub and the other pharmacy. And the pharmacist needed to make sure the prescription was clinically appropriate too. The pharmacy team told people that their prescription may be sent to another pharmacy to be made up. But unlike a compliance pack dispensed at the hub, the medicine made up at the other pharmacy didn't make it clear it was assembled elsewhere. 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. The pharmacy used reminder stickers to alert its team when these items needed to be added or if extra counselling was needed. And assembled CD prescriptions awaiting collection were 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. They were aware of the new rules on dispensing valproate-containing medicines in the manufacturer's original full pack. And they had the resources they needed when they dispensed a valproate.

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. But a few cartons containing medicines without a known batch number, or that were out of date, were removed from the dispensary shelves and quarantined during the inspection. Members of the pharmacy team marked the 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 usually recorded to show they had done so. And they marked products which were soon to expire. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. It stored its CDs, which weren't exempt from safe custody requirements, securely. Its team recorded the destruction of the CDs that people returned to it. And it kept these and out-of-date CDs separate from in-date stock. The pharmacy accepted the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed into one of the pharmaceutical waste bins. But the pharmacy team sometimes didn't follow the company's process for the disposal of unwanted or out-of-date medicines. And, for example, what had been returned wasn't always checked, and spent sharps and patient-returned CDs were found in the pharmaceutical waste bins. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And a team member described the actions they took and demonstrated what records they made when the pharmacy received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And its team makes sure the equipment it uses is clean and suitable for what it's being used for.

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 the medical refrigerators it needed to store pharmaceutical stock requiring refrigeration. And its team checked and recorded each refrigerator's maximum and minimum temperatures on the days the pharmacy was open. The pharmacy had a breath carbon monoxide monitor it used to help people when they wanted to give up smoking. It also had equipment for measuring a person's blood pressure and blood cholesterol and glucose levels. And all of these appeared to be well maintained with contact details available for servicing when required. 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 positioned its computer screens so they could only be seen by a member of the pharmacy team. But it could do more to make sure NHS smartcards were stored securely when that team member wasn't working at the pharmacy.

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.