General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kamsons Pharmacy, 92 High Street, Ashford, Kent, TN24 8SE

Pharmacy reference: 9010009

Type of pharmacy: Community

Date of inspection: 19/05/2023

Pharmacy context

The pharmacy is located on a busy high street in a town centre, and it receives most of its prescriptions electronically. It provides NHS dispensing services and a range of additional services. Including the New Medicine Service, travel vaccinations, chlamydia treatment, contraceptive service, and smoking cessation. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And people using the pharmacy can provide feedback about its services. Team members understand their role in protecting vulnerable people. And the pharmacy largely keeps its records up to date and accurate. But it doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs), and team members had signed to show that they had read, understood, and agreed to follow them. The pharmacist highlighted any near misses, where a dispensing mistake was identified before the medicine had reached a person, with the team member involved at the time of the incident where possible. And the team member was then responsible for identifying and rectifying their mistake. Some near misses had been recorded but this was not consistent. The pharmacist said that he would ensure that all near misses were recorded in future, and these would be reviewed regularly for patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist said that there had not been any recent dispensing errors, where a dispensing mistake had reached a person. He explained that he would record them, undertake a root cause analysis, and inform the pharmacy's head office. The pharmacy's complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. Team members said that there had not been any recent complaints.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. Team members said that the pharmacy would open if the pharmacist had not turned up in the morning. And they would contact the pharmacy's head office. The team were unsure about some of the tasks that should not be undertaken if there was no responsible pharmacist (RP) signed in. But they knew they should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. There were signed in-date patient group directions available for the relevant services offered. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals and this activity was documented. The private prescription records were largely completed correctly, but the correct prescriber details were not always recorded. The right RP notice was clearly displayed, and the RP record was largely completed correctly. But there were a few occasions recently when the RP had not completed the record when they had finished their shift and a different pharmacist was working the following day. The pharmacist

said that he would ensure that the private prescription records and the RP record were completed correctly in future.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. And other team members had undertaken some safeguarding training provided by the pharmacy's head office. The trainee dispenser described potential signs that might indicate a safeguarding concern and said that they would refer any concerns to the pharmacist. There had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions to help improve the systems in the pharmacy. And they can make professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one full-time pharmacist, one trainee dispenser, one trained medicines counter assistant (MCA) and one trainee MCA working during the inspection. Team members had either completed an accredited course for their role or they were undertaking training. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. This helped the pharmacy to keep up to date with its dispensing.

The MCA appeared confident when speaking with people. And she asked relevant questions to establish whether an over-the-counter medicine was suitable for the person it was intended for. She was aware of the restrictions on sales of pseudoephedrine-containing products. And said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care.

Team members received online training modules from the pharmacy's head office. And they were allowed time to complete these at work. Each team member had their own training record to keep track of training that had been completed. And the pharmacist monitored these. The pharmacy received an employee newsletter from the pharmacy's head office highlighting important information. Team members said that other information was passed on informally during the day and there were no formal team meetings. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they had yearly appraisals and performance reviews.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And he had recently completed some training about the contraceptive service. He felt able to make professional decisions. And he had completed declarations of competence and consultation skills for the services offered, as well as associated training. Targets were not set for team members. The pharmacist said that the pharmacy provided its services for the benefit of the people using it.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter, and he intervened during the inspection when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

The consultation room was accessible to wheelchair users, and it could be accessed from the shop area or from the dispensary. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls which helps make sure that its medicines and devices are safe for people to use. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy could produce large-print labels for people who needed them.

Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that he checked monitoring record books where available for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept at the pharmacy. And this could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said team members checked CDs and fridge items with people when handing them out. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy had the relevant patient information leaflets or warning cards available and warning stickers for use with split packs. The pharmacist said that he would refer people to their GP if they were not on a PPP and needed to be on one.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked frequently, and this activity was recorded. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. Medicines with fewer than three months shelf-life were removed from dispensing stock. The fridge was suitable for storing medicines and was not overstocked. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked regularly, and items remaining uncollected after around three months were returned to dispensing stock where possible and uncollected prescriptions were returned to the NHS electronic system.

The pharmacist said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before

people needed their medicines. Prescriptions for 'when required' medicines were not always routinely requested. The pharmacist said that people usually contacted the pharmacy if they needed these medicines when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines. But the patient information leaflets were not routinely supplied. And this could make it harder for people to have up-to-date information about how to take their medicines safely. Team members said that they would ensure that these were supplied in future. Team members wore gloves when handling medicines that were placed in these packs.

CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned, and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded on a hand-held electronic device. The pharmacy could access the information to check that an item had been delivered and at what time. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference which made it easier for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Suitable equipment for measuring liquids was available but not for volumes less than 10 millilitres. The pharmacist said that he would order a suitable measure.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced in accordance with the manufacturer's guidance. And the weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.