General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 62 Rawlinson Street, BARROW-IN-FURNESS, Cumbria, LA14 2DN

Pharmacy reference: 1030153

Type of pharmacy: Community

Date of inspection: 05/03/2024

Pharmacy context

This is a community pharmacy in a residential area of the town of Barrow-in-Furness, Cumbria. Its main services include selling over-the-counter medicines, dispensing NHS prescriptions, providing the NHS Pharmacy First and NHS Hypertension Case Finding services. It delivers medicines for some people to their homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 appropriately manages the risks with its services and provides them safely and efficiently. It keeps people's sensitive information secure, and team members are well equipped to help safeguard vulnerable adults and children. The pharmacy's team members follow a process to record the mistakes they make during the dispensing process. And they make some changes to the way they work to reduce the risk of similar mistakes recurring.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs). They covered tasks such as dispensing, responsible pharmacist requirements and controlled drug (CD) management. The SOPs were scheduled to be reviewed every two years. Several had review dates of 2022. There were newer electronic SOPs, but not every team member was aware of them. The importance of following the most up-to-date SOP was discussed with the team. All team members had read SOPs that were relevant to their role, and some had signed a document to confirm this. Team members were required to complete a short assessment following the completion of each SOP. The assessment was used to confirm team members correctly understood the SOP and knew how to follow it.

The responsible pharmacist (RP) or an accuracy checking pharmacy technician (ACPT) spotted errors made and identified by team members during the dispensing process, known as near misses. They informed the dispenser of the error and asked them to rectify the mistake. The pharmacy had a near miss log for team members to use to record details of each near miss. The log had sections to record details such as the type of near miss and the reason it might have happened. However, team members had not made any records of near miss errors since July 2023 and so they may have missed the opportunity to identify any trends or patterns. Team members made attempts to discuss near misses when they happened so they could all learn from each other's mistakes and consider ways to improve the way they worked to reduce the risk of similar mistakes happening again. For example, team members recently changed the way they stored medicines that had similar names. This helped reduce the risk of them being dispensed in error. There was a notice displayed on a dispensary wall that outlined the most common medicines that had similar names. For example, amlodipine and amitriptyline. The pharmacy kept records of any dispensing errors that had reached people. A form was completed which contained details of the error, reasons the error might have happened, and the actions taken to prevent a similar error recurring. Details of each dispensing error was shared with the pharmacy's head office and a copy was retained for future reference. The pharmacy had a concerns and complaints procedure in place. It was clearly outlined for people through a notice displayed in the retail area. Any complaints or concerns were required to be raised verbally with a team member. If the matter could not be resolved by the team member, it was escalated to the pharmacy's head office.

The pharmacy had current professional indemnity insurance. The RP notice displayed the name and registration number of the RP on duty. However, the notice was some distance from the retail area and therefore was not clearly visible to people who used the pharmacy. Entries in the RP record mostly complied with legal requirements. However, on some occasions the RP had not recorded the time their RP duties had ended. The pharmacy kept records of private prescriptions. Most of the records were complete, however on some occasions the details of the prescriber were not recorded. The pharmacy kept CD registers and records of CDs returned by people to the pharmacy. The CD registers were

audited against physical stock regularly. The physical stock of a CD was checked against the running balance in the CD register and they were found to be correct. The pharmacy kept complete records of CDs that had been returned to the pharmacy for destruction. It kept complete records of supplies of special medicines.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bag to avoid being mixed with general waste. The waste was periodically destroyed using a shredder. Team members understood the importance of keeping people's private information secure and they had all completed information governance training as part of their employment induction process. The RP had completed training on safeguarding vulnerable adults and children via the Centre of Pharmacy Postgraduate Education. Other team members had completed internal training and were aware of their responsibilities and when they should escalate any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a skilled and experienced team to help manage its workload. Team members are adequately supported to update their knowledge and skills. They provide feedback on the pharmacy's services and implement measures to improve efficiency and patient safety.

Inspector's evidence

At the time of the inspection, the RP was a locum pharmacist. The pharmacy employed a pharmacist manager who was not present during the inspection. The RP was supported by a full-time ACPT and two full-time qualified pharmacy assistants. Team members who were not present during the inspection included a part-time pharmacy technician and two part-time delivery drivers. Team members explained they were normally able to efficiently manage the pharmacy's workload when a team member was absent however the pharmacy's head office team ensured a relief ACPT supported the team when the employed ACPT was absent. This ensured the RP was not overburdened with prescriptions that needed an accuracy check and could continue to efficiently provide other services to people. Throughout the inspection, team members were observed working well and dispensing medicines under no significant pressure. They supported each other in completing various tasks and requested the support of the RP when needed for sales of medicines.

The pharmacy provided some training material for team members to use. The material was provided on an ad-hoc basis. Recently, the team had completed training on the NHS Pharmacy First service. Team members attended ad-hoc team meetings which were led by the pharmacy manager. They discussed company-related news, workload, near misses and dispensing incidents, and were able to provide feedback to help improve the pharmacy's services. For example, the team had recently implemented a system to use different coloured baskets (green for the RP and white for the ACPT) to store medicines awaiting a final check. This helped reduce the risk of any medicines being supplied to people without a clinical check being completed by the RP. There were some targets set for pharmacy services, but the team felt that these were appropriate and did not feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services the pharmacy provides to people. And the premises are maintained to a high standard. There is a private consultation room available for people to use to have confidential conversations with a pharmacy team member.

Inspector's evidence

The pharmacy was clean, highly professional in appearance and well maintained. The dispensary was tidy and well organised with designated areas for team members to dispense medicines and for the RP to complete final checks of prescriptions. Floor spaces were mostly kept clear to prevent the risk of a trip or a fall. The pharmacy had a spacious consultation room for people to have private consultations with team members. It was suitably equipped and soundproofed to prevent conversations being overheard by other people in the retail area.

The pharmacy had a clean sink in the dispensary that was used for the preparation of medicines. There were sinks in both the toilet and staff area which provided hot and cold water and other handwashing facilities. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a wide range of services which are made easily accessible to people. The pharmacy team manage the services well. Pharmacy team members follow robust processes to make sure the pharmacy stores and manages its medicines correctly.

Inspector's evidence

There was stepped access into the pharmacy from the main entrance door. Team members explained how they helped people with pushchairs or prams to enter the premises. They generally served people who used wheelchairs at the entrance door. There were seats available in the retail area for people to use while they waited for their prescriptions to be dispensed. Large-print labels were provided on request to help people with a visual impairment. Team members had access to the internet which they used to signpost people requiring services that the pharmacy did not offer. They used written communication to help people with a hearing impairment. Team members were comfortable using language applications to support people who were unable to communicate in English. The pharmacy had a 'healthy living area'. This was a space in the retail area dedicated to providing information about various healthcare topics and conditions. There were posters about hypertension, diabetes, atrial fibrillation and leaflets that people could take away to read. People who were identified as being eligible for the NHS Hypertension Case Finding service were directed to the area by team members. Team members demonstrated examples of where they had identified people who had raised blood pressure. This included giving dietary advice or referring them to their GP where appropriate, Team members had all received training about the service before it started. They explained how they used the information in the area to help people learn more about the risks of having high blood pressure and how it can be controlled. The pharmacy had recently started providing the NHS Pharmacy First Service. Team members described how the service had been extremely popular, but they had ensured the efficiency of other services were not compromised.

Team members used various alert stickers to attach to bags of dispensed medicines. The stickers reminded team members to complete an action before they handed these medicines to people. For example, to highlight that the bag contained diabetic medication or the presence of a medicine that required cold storage, or a CD that needed handing out at the same time. The team used clear bags to store all dispensed medicines that required cold storage. This was to support team members to complete another final check. Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to keep prescriptions and medicines together which reduced the risk of them being mixed up. There were separate dispensing and checking areas in the dispensary. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person, and one was kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They demonstrated the advice they would give in a hypothetical situation.

Most of the prescriptions received by the pharmacy were electronic prescriptions. Many of these prescriptions were sent to be dispensed at another of the company's pharmacies, known as the central hub pharmacy. This helped to reduce the dispensing workload pressure on the team and give them

more time to provide other services to people. The pharmacy generally sent prescriptions that were non-urgent to the central hub pharmacy. More urgent prescriptions such as those for antibiotics or for medicines that needed storing in a fridge, were dispensed on the premises. Data from prescriptions that were to be dispensed at the central hub pharmacy was entered onto an electronic system by a team member. The information was then checked to ensure it was accurate by an ACPT. The RP clinically checked each prescription and signed a printed copy of the prescription once this process was complete. It took around two to three days for the dispensed medicines to arrive at the pharmacy after the prescription had been submitted to the central hub pharmacy. The team had the ability to override the system and manually dispense any prescriptions that had already been sent to the hub. For example, team members explained they could do this if a person decided they needed their medicines sooner than they expected. Team members explained the system had made them more efficient and helped reduce the time they were taking in finding people's dispensed medicines. The team obtained mobile phone numbers from people so they could be alerted by text message that their medicines were ready to collect. This helped to reduce the number of times people presented at the pharmacy before their medicines were ready to collect.

Pharmacy (P) medicines were stored behind the pharmacy counter. Prescription only medicines were kept in restricted areas of the premises, and they were stored tidily on shelves and in drawers. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The CD cabinets were well organised and out-of-date and patient-returned CDs were appropriately segregated. The pharmacy had a medical grade fridge. The team used it to store medicines in that required cold storage. The contents of the fridges were well organised, and the team monitored and recorded the minimum and maximum temperature ranges of both fridges each day. The records seen were within acceptable ranges.

The pharmacy had a process to check the expiry dates of its medicines every three months. The team was up to date with the process. No out-of-date medicines were found after a check of around 20 randomly selected medicines. The pharmacy attached stickers to medicines to highlight them if they were expiring in the next 12 months. The date of opening was recorded on medicines that had a short shelf life once they had been opened. The pharmacy received drug alerts and recalls. The team quarantined any affected stock and a record of the action taken was retained.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities to safely manage its services. The equipment is well maintained to ensure it is fit for purpose.

Inspector's evidence

Team members had access to up-to-date reference sources including access to electronic copies of the British National Formulary (BNF) and BNF for children. The pharmacy used a range of CE marked measuring cylinders. There was a suitable, electronic blood pressure monitor to support the team in taking blood pressure measurements. The monitor was scheduled to be replaced each year. There was an otoscope used to undertake ear examinations. The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It positioned computer screens to ensure people couldn't see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private.

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.