General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Cohens Chemist, 10 Market Place, ULVERSTON, Cumbria, LA12 7DX

**Pharmacy reference:** 1030238

**Type of pharmacy:** Community

**Date of inspection:** 09/10/2019

## Pharmacy context

This is a community pharmacy in the centre of Ulverston, Cumbria. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including a home delivery service, seasonal flu vaccinations, medicines use reviews (MURs), a substance misuse service and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own 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 has suitable processes and written procedures to help protect the safety and wellbeing of people who access its services. It mostly keeps the records it must be law. And it keeps people's private information safe. The pharmacy listens to feedback from people using the pharmacy and makes changes to help improve its services. The team members record and learn from any errors they make when dispensing. And they take steps to prevent the error happening again. They know how to help protect the welfare of children and vulnerable adults. And they have some processes in place to support them.

### Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). There was an index. And so, it was easy to find a specific SOP. The superintendent pharmacist's team reviewed each SOP every two years. This ensured that they were up to date. There was a matrix which listed the SOPs that each team member needed to follow, depending on their role, for example delivery driver. The team members said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with. The team members were required to complete a short assessment on certain 'core' SOPs such as taking in prescriptions and dispensing. They needed to pass the assessment to be signed off as having read and understood its contents.

The pharmacy had a process to record near miss errors that were spotted during dispensing. The pharmacist typically spotted the error and then informed the dispenser that they had made an error. The dispenser made a record of the error onto a paper near miss error log. The details recorded included the time, date and description of the error. The team members discussed any errors with each other while they were making the entries on the log, so they could learn from each other. But they did not record why errors had happened. And so, they may have missed out on some learning opportunities. The pharmacist had recently discussed with the team members the importance of recording the details of why errors happened, which would help him identify any trends or patterns in the errors. The pharmacist completed a formal analysis of the errors each month and the findings were discussed in a monthly team meeting and documented for future reference. During the most recent meeting, the team members discussed taking extra care when selecting medicines that look or sound alike, known as LASA medicines. They had a list of the most common LASA medicines displayed on a wall and attached alert stickers next to where some of these medicines were stored. The purpose of the stickers was to remind the team members that there was potential for a selection error with the medicine and to take extra care. The pharmacy had a process to record dispensing errors that had been given out to people. And it recorded these incidents electronically. The team members completed a root cause analysis and discussed how they could learn from the error and prevent it happening again. A copy of the report was sent to the superintendent pharmacist's office for analysis and kept in the pharmacy for future reference. The pharmacy had recently supplied a medicine in error. The tablet form of the medicine was supplied instead of the capsule form. The team members discussed ways they could stop a similar error happening in the future.

The pharmacy had a poster on display in the retail area which advertised how people could make comments, suggestions and complaints. It detailed the company head office contact details. A team member described how she would escalate any concerns or complaints from people who used the

pharmacy. The pharmacy collected feedback from people through an annual survey. And the results of the 2018 survey were displayed and were positive overall. One area for improvement was for the team to give more comprehensive advice on healthy living. The pharmacy had trained two team members as healthy living champions.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record were not always complete as on several days the pharmacist had not recorded when their responsible pharmacist duties had ended. This is not in line with requirements. The pharmacy kept complete records of private prescriptions and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. But in a sample seen, these were not always completed correctly as required by the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy kept controlled drugs (CDs) registers. These were in order including completed headers, and entries made in chronological order. The pharmacy team checked the running balances against physical stock each week. The running balance of fentanyl 12mcg patches was checked and it matched the physical stock. The pharmacy kept complete records of CDs returned by people to the pharmacy.

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 bin to avoid a mix up with general waste. A third-party contractor periodically destroyed the confidential waste. The pharmacy displayed a poster explaining how people's information was used and stored. The team members understood the importance of keeping people’s information secure. And they had all completed training on information governance.

The regular pharmacist and a pharmacy technician had completed additional training via the Centre for Pharmacy Postgraduate Education to level 2. The pharmacist had recently refreshed his training. The team members gave several examples of symptoms that would raise their concerns. And how they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The team members had some guidance readily available to them to help properly manage and report a potential concern. And they knew to contact the local safeguarding teams or the superintendent pharmacist’s office for advice if they had any concerns.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough suitably skilled team members to manage the services it provides. The pharmacy supports its team members to ensure their knowledge and skills are up to date. It achieves this by providing its team members with a structured training programme. And they can discuss their performance during regular appraisals. The team members feel comfortable to raise professional concerns when necessary. They openly discuss how to improve ways of working. And they regularly talk together about why mistakes happen, and how they can make improvements.

### Inspector's evidence

At the time of the inspection, the team members present were the regular pharmacist who was also the pharmacy manager, a pharmacy technician and two trainee pharmacy assistants. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The pharmacy could call on the help of team members from other local Cohens branches to cover planned and unplanned absences. The pharmacist organised the working rotas four weeks in advance. The team felt that they had enough staff to manage the workload when all the team members were present but had recently struggled slightly with the workload as the staffing hours had been reduced. The pharmacy was recruiting for a full-time qualified or trainee pharmacy assistant. The pharmacist was seen supervising the team members while they worked. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. The team members accurately described the tasks that they could and could not perform in the pharmacist's absence.

The team members had access to various training material which they used to make sure their knowledge and skills were up to date and regularly refreshed. They explained that this helped them provide a high standard of care and advice to people who had questions about their health or were interested in purchasing a healthcare related product. The pharmacist provided the team members with set time to complete training. And so, they were able to complete their learning without any distractions. But they were not always able to take this protected time, due to the dispensing workload. The team members were required to keep records of any completed training modules. Many modules that were completed were sent from the company's head office and were mandatory for the team members to work through. The team members could tailor their training to their own personal needs if they wished. For example, a team member explained that she had recently asked for time to learn about the destruction of patient returned and expired CDs. So, she could understand the requirements. The pharmacy had an annual performance appraisal process in place. Before each appraisal, they team members assessed their own performance over the last year. They discussed their assessment with the pharmacy's manager in a one-to-one meeting. They also discussed what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. They could give feedback on how to improve the pharmacy's services.

The team held monthly formal meetings and discussed topics such as company news, targets and patient safety. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. The team members said they were able to discuss any professional concerns with the manager or with the

company head office. The pharmacy had a whistleblowing policy. So, the team could raise a concern anonymously. The pharmacy set several targets for its team to achieve. These included services and prescription volume. The team members were well supported to help them achieve the targets.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is secure, clean and properly maintained. And, it has a suitable room where people can speak to pharmacy team members privately. The space the team members use for dispensing is tidy. But some staff only areas of the pharmacy are cluttered and may present a trip hazard.

### Inspector's evidence

The pharmacy had a large retail space and a large dispensary. It was clean and was professional in its appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was tidy and well organised during the inspection and the team had ample bench space to organise the workflow. Floor spaces were cluttered in many areas of the pharmacy, including stock rooms. And so, there was a risk of trips and falls.

There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities and a computer terminal. The room was smart and professional in appearance and was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides services that support people's healthcare needs and makes them accessible to people. The team members take appropriate steps to identify people taking high-risk medicines. And, they provide these people with relevant advice to help them take these medicines safely. It dispenses medicines in multi-compartmental compliance packs to help people take their medicines correctly. And the team members manage the service effectively. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages its medicines appropriately. But it doesn't always complete the process of checking the expiry dates of medicines.

### Inspector's evidence

The pharmacy was accessible from a push button, power assisted door from street level and from steps to the main entrance from the street to a push/pull door. The pharmacy advertised its services and opening hours in the front window. Seating was provided for people waiting for prescriptions. Large print labels were provided on request. The pharmacy was a healthy living pharmacy and there was a healthy living zone located near the waiting area. It displayed several posters and leaflets that people could select and take away with them. The team members had access to the internet allowing them to signpost those patients requiring a particular service. The pharmacy had various disability aids in stock and on display. These were either sold to people or supplied via prescriptions issued by Furness General Hospital. The team members had received training on the products and were seen recommending aids to people who had questions about them.

The team members regularly used various stickers that they could use as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines. This helped the team stop people's prescriptions from getting mixed up. The team annotated alert stickers to highlight the expiry date of CD prescriptions awaiting collection. And this helped them prevent handing out CDs after the prescription had expired. 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 kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy often dispensed high-risk medicines for people such as warfarin, lithium and methotrexate. The team members demonstrated how the computer system displayed a pop-up alert when they generated dispensing labels for prescriptions for such medicines. The alert reminded the team to ask people various questions and provide appropriate advice on how they should be taking their medicines. The pharmacist explained he ensured he asked people taking warfarin if he could look at their anticoagulant book and reminded them of the importance of regular blood tests. The team

occasionally recorded details of the conversations if they were significant, for example a discussion about a change in dose or directions. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme to provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. None were identified. The pharmacy used clear bags to store dispensed insulin. This allowed the team member and the person collecting it to undertake a final visual check of the medicine before handing it out.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes. Some were dispensed by the team on the pharmacy premises, but most of them were dispensed at an offsite dispensing hub. The team members were responsible for ordering the prescriptions. And they did this around two weeks in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. A dispenser inputted the details of the prescription onto an online system if the pack was to be dispensed at the hub. The pharmacist then double checked the details entered to make sure they matched the details on the prescription. He then signed off the details using his registration number and the details were electronically transferred to the hub. The team faxed the original copies of the prescription to the hub, so they could be checked for accuracy. The packs arrived back at the pharmacy after around a week. The packs dispensed at the hub included backing sheets with images of the medicines which could be used to identify them. The team members provided people with backing sheets if the packs were dispensed at the pharmacy, but they did not always provide people with a way to visually identify the medicines. The packs dispensed at the pharmacy were sent to people with patient information leaflets, but the packs dispensed at the hub were not.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. Every three months, the pharmacy team members checked the expiry dates of its medicines to make sure none had expired. But the pharmacy was around eight weeks behind with the process. The pharmacy used stickers to highlight stock that was within six months of expiring. Some short-dated stickers were seen on items on the dispensary shelves. Eight out-of-date medicines were found following a random check of approximately 20 items. Each of these items had a short-dated sticker attached to it. The team explained they would always check the expiry date of each medicine before they dispensed it. And this process was seen during the inspection. The importance of keeping up to date with the process was discussed with the team members. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received training on how to follow the directive. The pharmacy had FMD software and scanners installed. The team was unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy had two fridges. And the team members checked the temperatures of each fridge each day. To make sure they were within the correct ranges. And the temperatures recorded were within the correct limits. The CD cabinets were secured and of an appropriate size. The medicines inside were well organised.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

### Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team members used tweezers and rollers to help dispense multi-compartmental compliance packs.

The fridges used to store medicines were of an appropriate size. And the medicines inside were organised in an orderly manner. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private. There was no evidence the electrical equipment had been subjected to portable appliance testing. But the equipment looked to be in good working order.

## 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. |