General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Coopers Chemists, 12 The Glebe, Chells, STEVENAGE, Hertfordshire, SG2 0DJ

Pharmacy reference: 1032306

Type of pharmacy: Community

Date of inspection: 15/11/2022

Pharmacy context

This community pharmacy is in a parade of shops in a residential area of Stevenage, Hertfordshire. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing health advice to people. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service to people's 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 identifies and manages the risks associated with its services. It keeps people's private information secure. And it uses the feedback that it receives to inform how it manages its services. The pharmacy keeps the records it must by law. Its team members understand how to recognise and respond to safeguarding concerns. And they engage in some conversations to help reduce risk following mistakes made during the dispensing process.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) designed to support its safe and effective running. These covered the responsible pharmacist (RP) role, controlled drug (CD) management and pharmacy services. The SOPs had been prepared in October 2020 and all team members had read and signed those relevant to their role. A team member demonstrated sound knowledge of the tasks that couldn't take place if the RP was absent from the premises.

Pharmacy team members generally recorded mistakes found and corrected during the dispensing process, known as near misses. A member of the team explained that they discussed their near misses. But acknowledged that they may sometimes forget to record the mistake when the pharmacy was particularly busy. And the team used the action section of the near miss record to record immediate steps taken to correct the mistake, rather than the action taken to reduce future risk. The pharmacy had a robust system for reporting mistakes identified after a medicine had been supplied to a person, known as dispensing incidents. This included maintaining its own record of the incident, putting flash notes on people's records to help reduce the risk of a similar event occurring and sharing learning anonymously to help inform national patient safety bulletins. The pharmacy kept a record of these bulletins to help it review its own processes. For example, reviewing the placement of stock medicines commonly involved in dispensing incidents. It also displayed a range of learning posters within the dispensary designed to prompt extra checks of medicines that looked alike, or that had similar names. The pharmacy had carried out a patient safety review within the last year. This identified patterns in mistakes and the actions taken to reduce the risk of similar mistakes occurring. But this was an annual review which meant there could be some delay in measuring the effectiveness of the actions taken to reduce risk.

The pharmacy had a complaints procedure, and this was advertised to members of the public. Team members understood how to manage feedback and escalate the feedback they received. They provided examples of how they had shared feedback with surgeries to help support improvements to the management of the pharmacy's repeat prescription collection service. The pharmacy had guidance available to support its team members in maintaining people's confidentiality. All team members on duty demonstrated how they worked to manage people's confidential information securely. The pharmacy stored personal identifiable information in staff-only areas of the premises. The pharmacy had adequate processes for managing and destroying its confidential waste.

The pharmacy had up-to-date indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. A sample of the Prescription Only Medicine (POM) register, Specials records and the CD register met requirements. There were occasional missed sign-out times within the RP

record. The pharmacy maintained running balances in its CD register. And there was evidence of physical balance checks of stock taking place against the register regularly. A random physical balance check conducted during the inspection complied with the running balance in the register. The pharmacy had a patient-returned CD destruction register, and this was kept up to date.

The pharmacy had safeguarding procedures in place. The RP had completed level two safeguarding learning through the Centre for Pharmacy Postgraduate Education (CPPE). And other team members had completed some learning on the subject to support them in their roles. Pharmacy team members understood the importance of acting on safeguarding concerns. And the RP provided evidence of records they had made following a referral to a safeguarding agency. Some, but not all team members had an awareness of the 'Safe Spaces' and 'Ask for ANI' safety initiatives, designed to help provide a safe space for people experiencing domestic abuse. A discussion took place to highlight the benefits of introducing some learning on the subject to support team members in responding to these types of requests for help.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small, dedicated team of people who work together well. Pharmacy team members demonstrate enthusiasm for their roles. They engage in some continual learning to support them in delivering the pharmacy's services. And they understand how to provide feedback at work.

Inspector's evidence

The RP on duty was the pharmacy manager. They were working alongside a qualified dispenser, a medicine counter assistant (MCA) and a trainee pharmacist. The pharmacy employed another dispenser and another MCA. A company employed driver provided the medicine delivery service three days each week. The pharmacy was busy throughout the inspection. The team explained that local surgeries were running behind with issuing prescriptions following a merger taking place. This meant the pharmacy received a large volume of prescriptions in bulk several times a week, it made the pharmacy particularly busy on these days. The pharmacy team was observed working well to manage this workload by downloading and processing the prescriptions and ensuring stock was available to fill the prescriptions. This meant it could quickly locate a prescription and dispense them if people attended to collect their medicines.

The pharmacy displayed certificates relating to the qualifications of its team members. The trainee pharmacist confirmed they felt supported with their learning. And they received protected training time each week. They understood how to raise any concerns they had about their learning needs if required. There was some evidence of ongoing learning in the pharmacy relating to the services provided. But team members did not receive regular protected learning time or formal appraisals to support them in their learning and development. Pharmacy team members recognised the importance of referring queries to the RP. And they worked well to promote the pharmacy's services to both members of the public and other healthcare professionals. The pharmacy did not have specific targets in place associated with the services provided.

Team members worked together well. They communicated regularly about workload management and patient safety. But they did not regularly record the outcomes of these conversations to help share learning from safety events. The pharmacy had a whistleblowing policy. A section within the policy relating to the need to nominate a 'freedom to speak up guardian' was not completed. But team members understood how to provide feedback at work. The RP provided an example of recent feedback relating to staffing levels being taken onboard by the owners. The pharmacy team was encouraged to seek the assistance of the company's relief team to support it in managing its workload during periods of leave, or when the pharmacy was particularly busy.

Principle 3 - Premises ✔ Standards met

Summary findings

Pharmacy team members work well in the space provided. And they promote access to the pharmacy's private consultation facilities. The pharmacy premises are clean and secure. They are generally maintained to an adequate standard but need some attention to ensure good access to sinks equipped with running water and hand-washing supplies.

Inspector's evidence

The pharmacy was clean and secure against unauthorised access. Team members reported that urgent maintenance issues were dealt with in a timely manner. But there were some maintenance issues that had not been dealt with. This included only one of the two toilets in the premises being in working order, and the only working sink in the pharmacy was the dispensary sink. This was because both toilet sinks were out of order. An air conditioning unit and electric heaters were in use to maintain an ambient temperature. Lighting was adequate throughout the premises.

The public area of the pharmacy was fitted with wide-spaced aisles. A signposted consultation room was available to the side of this area. The room was big enough to accommodate a wheelchair. Team members used a separate entrance to the room from the front of the dispensary, this allowed them to control access to the room. The use of this private consultation space was seen to be offered to people. The dispensary had limited workbench space for the level of activity taking place. The floor was free from trip hazards. The team stored assembled medicines waiting to be checked in an organised way which supported an effective workflow. Off the dispensary there was access to staff toilet facilities and a good amount of storage space. The team used the storage space effectively to hold dispensary sundries, dressings, and excess stock. There was also designated shelving in this area used to support the management of the multi-compartment compliance pack service.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy ensures that its services are accessible to people. It obtains its medicines from reputable sources. And it stores its medicines safely and securely. Pharmacy team members recognise the benefits of engaging people in conversations about their health and their medicines. And they document the outcome of these interventions to support ongoing care. But there are occasions when pharmacy team members work outside of documented procedures when assembling medicines in multi-compartment compliance packs. This could mean they are not always working in the safest and most effective way.

Inspector's evidence

The pharmacy was clearly signposted and accessible to people. It displayed details of its opening times clearly. Some information leaflets were available for people to take; these included a copy of the pharmacy's practice leaflet. The pharmacy provided the seasonal flu vaccination service and it scheduled appointments carefully to help balance workload in the dispensary. It had seen a large increase in referrals associated with the NHS Discharge Medicines Service (DMS). And it had sound processes in place to ensure it picked up these referrals efficiently. Team members liaised well with GP surgery teams to ensure the pharmacy received the correct prescriptions for people recently discharged from hospital. Pharmacy team members were aware of signposting requirements should the pharmacy be unable to provide a service or supply a medicine.

Activity at the medicine counter was busy throughout the inspection, with many requests for advice relating to minor ailments, and common health conditions. The pharmacy stored Pharmacy (P) medicines behind the medicine counter. And the RP had good supervision of the medicine counter from the dispensary. The pharmacy had robust systems for managing the supply of higher-risk medicines, including over-the-counter medicines liable to abuse, misuse and overuse. Pharmacy team members kept records of repeat requests for these medicines and the RP used the records to support interventions when repeat requests were received. The team reflected on the positive working relationship it had with the local medicines management team. The RP demonstrated audits relating to higher-risk prescription only medicines. Pharmacy team members had an awareness of most of the requirements of the valproate Pregnancy Prevention Programme (PPP) and had recently engaged in a conversation about appropriate placement of labels on boxes of valproate. A discussion during the inspection highlighted the need to detach patient cards and supply these alongside the valproate as part of the counselling process. The pharmacy team was good at recording interventions on the patient medication record (PMR) system. This included using flash notes on people's records to help prompt referral to the pharmacist. The trainee pharmacist was completing a review of the pharmacy's approach to monitoring checks associated with the supply of warfarin to help support their learning. Evidence of interventions recorded on the PMR included counselling and monitoring checks for higher-risk medicines, routine counselling when supplying medicines and details of prescribing interventions. The RP applied a risk rating of red, amber, or green to these interventions to help identify their clinical significance. Recording these types of interventions supported continual care and allowed team members to follow-up with people to support them in taking their medicines safely. Another action to support the safe supply of higher-risk medicines included reviewing the wording on medicine labels when dispensing methotrexate, to ensure people understood to take the medicine once weekly, on the

same day each week. The pharmacy highlighted prescriptions for schedule 2 and 3 CDs clearly to ensure they were handed out within 28-days of the date of prescribing.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form. It kept original prescriptions for medicines it owed to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy kept audit trails of the prescriptions it ordered and of the medicines it delivered. It did not currently require people to sign for receipt of their medicines through the delivery service due to changes it had implemented during the coronavirus pandemic. Pharmacy team members generally signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. But they did not routinely sign backing sheets when supplying medicines in multi-compartment compliance packs. The pharmacy had records to support the supply of medicines in this way. These records included the schedule for dispensing each person's compliance pack, details of the current medicine regimen and documented changes to medicine regimens. A team member assembled each compliance pack and left it with a basket containing the original packaging, prescription forms, patient information leaflets and backing sheets. But it was standard procedure for the RP to attach the backing sheet to the pack during the accuracy checking stage. This process did not reflect the details recorded in the pharmacy's SOPs for dispensing medicines. As the backing sheet 'label' in this case was not applied during the assembly process. A discussion highlighted how this way of working had the potential to increase the chance of a mistake being made. The pharmacy provided descriptions of the medicines inside the compliance packs, to help people recognise them. And it issued patient information leaflets at the beginning of each four-week cycle of packs.

The pharmacy sourced medicines from licensed wholesalers. It stored these medicines in an organised manner and within their original packaging. The pharmacy had secure cabinets for the storage of its CDs. And stock inside these cabinets was neat and orderly. The pharmacy had two fridges for medicines requiring cold storage. The fridges were an appropriate size for the amount of medicines stored inside. One team member took responsibility for recording fridge temperature records. But this meant there was some occasional gaps within the record. Temperatures recorded either side of these gaps confirmed the minimum and maximum temperatures had remained between two and eight degrees Celsius as required.

Pharmacy team members reported completing regular date checks of medicines. A record in the dispensary helped to schedule these checks. A random check of dispensary stock found no out-of-date medicines. Pharmacy team members annotated the opening date on liquid medicines with a shortened shelf life once opened. The pharmacy received drug alerts and recalls by email. And it kept an effective audit trail of the action it had taken in response to these alerts. The pharmacy had medical waste receptacles, CD denaturing kits and sharps bins available to support the team in managing pharmaceutical waste. Team members had recently begun to remind people to return their used inhalers to the pharmacy for safe disposal.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And its team members act with care by using the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date reference resources available including the British National Formulary (BNF). They accessed password protected computers and used NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicine out of direct view of the public area.

Pharmacy team members used appropriate counting and measuring equipment when dispensing medicine. The pharmacist providing the flu vaccination service had access to appropriate equipment to support them in providing this service. The equipment included immediate access to medicines and equipment used to treat an anaphylactic reaction. Electrical equipment was in working order and cables and plugs were visibly free from wear and tear.

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.