General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 193 Bolton Road, Kearsley, BOLTON, Lancashire, BL4 9BX

Pharmacy reference: 1033135

Type of pharmacy: Community

Date of inspection: 02/05/2019

Pharmacy context

This is a very busy community pharmacy located on a main road near to a medical centre. Most people who use the pharmacy are from the local area. The pharmacy dispenses mainly NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment devices to help people take their medicines at the right time. Most of these are prepared in another Cohens pharmacy in the Bolton area.

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 adequately manages risks and completes all the records that it needs to by law. Members of the pharmacy team work to professional standards. They record some of their mistakes, so that they can learn from them and they act to help stop the same sort of mistakes from happening again. The team members keep people's private information safe. And they complete training so they know how to protect children and vulnerable adults.

Inspector's evidence

There were up-to-date Standard Operating Procedures (SOPs) for the services provided with signatures showing that most members of the pharmacy team had read and accepted them. Roles and responsibilities of staff were set out in SOPs. One of the dispensers had not signed to indicate she had read the relevant SOPs, so may be unclear of her roles and responsibilities and who was accountable for what. The pharmacy team members were performing duties which were in line with their role. A work experience student from a local college was working in the pharmacy. She was clear about the duties she was allowed to perform which were tidying shelves, cleaning and date checking, as well as observing the team. Most team members were wearing uniforms and name badges showing their role. The name of the responsible pharmacist (RP) was displayed as per the RP regulations.

Dispensing incidents were reported to head office and a copy of the report retained in the pharmacy. Learning points were included. Following an incident when the incorrect strength of Durogesic patch was supplied, a report was made to head office and the Managing Support Pharmacist (MSP) visited the pharmacy to help the team investigate and learn from it. He made an additional report of the incident to the controlled drug (CD) Accountable Officer. A learning point was that the new running balance was recorded on the prescription, and this was checked before supplying the medicine to the patient, forming an additional check that the correct medicine, strength and quantity had been dispensed. Around four near misses had been reported during April 2019. The pharmacy manager said they were not always recorded especially when the pharmacy was busy, such as over the Easter period. Near misses and errors were reviewed monthly and a patient safety report completed and discussed with the pharmacy team at monthly huddles. There was shared patient safety learning in regular bulletins from head office. These were printed off and given to the team to read. A list of Look-alike and sound-alike drugs (LASAs) were on display in the dispensary and ‘Take care’ stickers were used to highlight the products on the dispensary shelves. Some of the dispensary shelves were very full and untidy, which might increase the risk of errors.

A dispenser described how she would deal with a customer complaint which was to take the person into the consultation room and record the details. She said the complaint would be reported and the details of head office given to the person, if the complaint could not be resolved in the pharmacy at the time. There was nothing on display in the pharmacy with the complaint’s procedure and the details of who to give feedback to, so people might not know how to raise a concern or leave feedback.

A customer satisfaction survey was carried out annually. The results of the most recent survey were on display and available on the NHS choices website. The pharmacy was rated 93% overall at the last

survey. Areas of strength were ‘How long you have to wait to be served’ (97%), ‘Disposing of medicines you no longer need’ (96%) and ‘Providing advice on health services or information available elsewhere’ (96%). An area identified which required improvement was ‘Providing general advice on leading a more healthy lifestyle’. The pharmacy’s published response was ‘We have trained Health Champions in every pharmacy who will use their skills to enhance the promotion of healthy lifestyles to our patients.’ There was very little visible health promotion in the pharmacy and one of the health champions said she had never provided healthy living advice as she had never been asked to, which did not demonstrate a proactive approach.

Insurance arrangements were in place. Private prescription and emergency supplies records, the RP record, and the CD register were appropriately maintained. Records of CD running balances were kept and these were audited. Two CD balances were checked and found to be correct. Adjustments to methadone balances were attributed to manufacturer's overage following an assessment of whether the adjustment was within a reasonable range and following investigation. Patient returned CDs were recorded and disposed of appropriately.

Confidential waste was collected in a designated place then sent to head office for disposal. Members of the pharmacy team correctly described the difference between confidential and general waste. The work experience student understood what it meant to maintain patient confidentiality and said she had signed a confidentiality clause when she started working in the pharmacy. Prescriptions awaiting collection were not visible from the medicines counter. A privacy statement was on display, in line with General Data Protection Regulations (GDPR).

Patients receiving their medicines in multi-compartment devices were informed that they could be dispensed at a different pharmacy/hub but consent for this was not recorded. A record was made if the patient opted out of this process and their MDS trays were not sent away for assembly.

The pharmacy manager and accuracy checking technician (ACT) had completed centre for pharmacy postgraduate education (CPPE) level 2 training on safeguarding. Other members of the pharmacy team had read the safeguarding SOP. A dispenser had completed some training as part of her NVQ3 course and said she would refer any concerns to the pharmacist. A delivery driver said he would voice any concerns regarding a vulnerable adult to the pharmacist working at the time. The pharmacy had a chaperone policy but there was nothing on display highlighting this to patients, so some people might not realise a chaperone was an option. Members of the pharmacy team had completed dementia friends training and so had a better understanding of patients suffering from dementia.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are properly trained for the jobs they do. They get some ongoing training. But this does not happen regularly, so it may not always meet their needs and means their knowledge may not be always fully up to date. The team members work well together. They are comfortable about providing feedback to their manager and receive feedback about their own performance. The pharmacy enables the team members to act on their own initiative and use their professional judgement to the benefit of people who use the pharmacy's services.

Inspector's evidence

There was a pharmacy manager (RP), an accuracy checking technician (ACT), five NVQ2 qualified dispensers (or equivalent), an overseas pharmacy technician carrying out voluntary work experience, a work experience student and a delivery driver on duty at the time of the inspection.

The pharmacy was busy, and the pharmacy team coped well with the heavy workload during the inspection. Planned absences were organised so that not more than one person was away at a time and a holiday chart was used. Absences of more than one member of the team were covered by re-arranging the staff rota or transferring staff from neighbouring branches. There was an area coordinator who assisted to arrange cover if necessary. There had been a vacancy for a dispenser for around 9 months, so this had increased the pressure on the team. The vacancy had now been filled and a new dispenser was soon to start. There were two regular relief pharmacists who covered the pharmacy manager's days off, ensuring consistency in the pharmacist cover. The pharmacy team were observed working collaboratively with each other and the patients.

Members of the pharmacy team had completed training on children's oral health and dementia but there was little other on-going training once the team members were qualified. The pharmacy team did not have regular protected training time. One dispenser was on the NVQ3 course but said she usually carried out this training in her own time, at lunchtime or before work, as it was too busy during working hours. She said she discussed aspects of her training with the pharmacy manager and colleagues when required.

There was a formal appraisal process where performance and development were discussed. The pharmacy manager said she was a little bit behind with this, due to the staff vacancy and busy Easter/bank holidays but she gave positive and negative feedback informally when possible. Informal staff huddles were held where a variety of issues were discussed, and concerns could be raised. Daily bulletins were received from head office which were discussed with the team, e.g. the reclassification of gabapentin and pregabalin to CD. A dispenser said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the pharmacy manager about any concerns she might have. She said the staff could make suggestions or criticisms informally, e.g. it was a staff suggestion to use an A-Z box file for prescriptions containing out of stock medicines, rather than a basket, to improve efficiency. There was a whistleblowing policy and a notice on display showing this.

The pharmacist said she felt empowered to exercise her professional judgement and could comply with

her own professional and legal obligations, e.g. refusing to sell a pharmacy medicine because she felt it was inappropriate. She said targets were set for medicine use review (MUR) and new medicines service (NMS), and the team were encouraged to achieve these, but she felt the targets were achievable and she didn't feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The pharmacy premises including the shop front and facia were reasonably clean and in an adequate state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with four chairs. A cleaning rota was used. The temperature and lighting were adequately controlled. Maintenance problems were reported to head office and the response time was appropriate to the nature of the issue, e.g. a recent issue with leaky guttering was promptly dealt with (within 48 hours), when reported.

Space was limited in the dispensary, but the work flow was organised into separate areas with a designated checking area. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available, but some were stacked on the floor which was a tripping hazard and risked contamination and physical damage to the medicines. The pharmacy manager explained this was very unusual practice and due to the particularly heavy workload that day as the bank holiday weekend was approaching.

There was a separate stockroom on the first floor where excess retail stock was stored. Staff facilities were on the first floor and included a kitchen area and a WC with a wash hand basin and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available.

There was a small consultation room equipped with a sink, which was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. The pharmacy team explained they used this room when carrying out services such as supervised methadone, and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people and they are generally well managed, so people receive their medicines safely. The pharmacy sources, stores and supplies medicines safely. And carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

There was a small step up to the front door of the pharmacy, but it was possible for customers to enter with prams and wheelchair users with assistance. There was a bell at the door and staff said they would always be ready to serve customers at the door if necessary.

Some of the services provided by the pharmacy were not advertised so patients might not realise they were offered. There was a range of healthcare leaflets in the consultation room, so only accessible to people using this room. There was a healthy living notice board with some healthy living advice, but it had not been updated, and was still promoting winter health and flu vaccinations which was not relevant to the current season. Some signposting information was on display in the consultation room, which could be used to inform patients of services and support available elsewhere. Signposting and providing healthy living advice were not usually recorded. It was therefore difficult to monitor the effectiveness of health promotion and signposting.

The pharmacy ordered repeat prescriptions for patients receiving their medicines in multi-compartment devices trays and contacted these patients regularly to check their requirements for medicines not in the trays, such as inhalers. Other patients ordered their own prescriptions, either directly with the surgery or by contacting the pharmacy with their requirements. This helped to reduce stockpiling and medicine wastage.

There was a delivery service and a robust audit trail was in place. Each delivery was recorded, and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. The delivery driver described the delivery process which was in line with the SOP. A privacy sheet was used to reduce the risk of breaching confidentiality when the recipient signed the delivery sheet.

Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. An ACT worked in the pharmacy. She initialled the prescription if she carried out the accuracy check and then passed it to the pharmacist for the clinical check. The clinical check was recorded on the master sheet for MDS trays.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Pharmacist' stickers were used to highlight counselling was required and high-risk medicines such as warfarin and methotrexate were targeted for extra checks and counselling. 'INR' stickers were used to highlight warfarin prescriptions and INR levels were requested and recorded when dispensing warfarin prescriptions. A valproate audit had been carried out and identified one female patient, but following discussion with the patient's GP, it was identified that she was not of child bearing potential. The valproate information pack and care cards were available to ensure female patients were given the

appropriate information and counselling.

The pharmacy supplied around 200 patients with medication in multi-compartment devices. Most of these were sent to a different pharmacy/hub to assemble. They were clearly labelled with the address of the pharmacy assembling them as well as the pharmacy supplying them. The process was well organised with an audit trail for communications with GPs and changes to medication. A dispensing audit trail was completed, and medicine identification was completed to enable identification of the individual medicines. Photos of the medication were on the trays assembled at the hub to aid identification. The pharmacy team confirmed packaging leaflets were included when trays were assembled in the pharmacy unless the patient specifically requested that they not be provided. Packaging leaflets were not supplied for the trays assembled at the hub, despite this being a mandatory requirement. Disposable equipment was used.

A dispenser working on the medicines counter knew what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in two CD cabinets which were securely fixed to the wall/floor. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used for the supply of medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out.

The pharmacy was not yet compliant with Falsified Medicines Directive (FMD). The required hardware was available but not yet in use. The pharmacy manager said they were waiting for training before they started scanning medicines and did not know if the software was on the computer system yet.

Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and designated bins were in place. The consultation room was not locked and contained a sharps bin with Victoza pens in it, risking unauthorised access.

Alerts and recalls were received via e-mail messages from the superintendent's office and the NHS area team. These were read and acted on by a member of the pharmacy team and filed. The pharmacy manager also received alerts and recalls from the Royal Pharmaceutical Society (RPS).

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely.

Inspector's evidence

Current British National Formulary (BNF) and BNF for children were available and the pharmacist could access approved professional websites through the intranet for the most up-to-date information.

There was a clean medical fridge. The minimum and maximum temperatures were being recorded daily and had been within range throughout the month. All electrical equipment appeared to be in good working order.

There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were marked and used for CDs. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.