

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 68-70 Coal Clough Lane, BURNLEY,
Lancashire, BB11 4NW

Pharmacy reference: 1033310

Type of pharmacy: Community

Date of inspection: 07/06/2024

Pharmacy context

This is a community pharmacy in a residential area of the town of Burnley, Lancashire. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. The pharmacy provides the NHS Pharmacy First Service, supplies some people with their medicines in multi-compartment compliance packs and delivers some medicines to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	The pharmacy employs some team members that are not actively undergoing training appropriate for their role in accordance with GPhC training requirements. And so, they carry out tasks for which they are not appropriately qualified or trained.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy team doesn't store and manage medicines that require cold storage as it should. And so, there is a risk some medicines may be supplied that are not fit for purpose.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy provides its team members with a set of written procedures to support them in managing its services. It keeps people's sensitive information secure, and its team members are adequately equipped to safeguard vulnerable adults and children. They make changes to the way they work to help improve dispensing accuracy.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs). The SOPs provided the pharmacy's team members with information and instructions on how to complete various tasks. For example, managing controlled drugs (CDs) and dispensing medicines. Team members signed a document to confirm which SOPs they had read and understood. The SOPs were due to be reviewed by the pharmacy's superintendent pharmacist (SI) office every two years. However, the SOPs inspected had not been reviewed since 2020. The team explained the pharmacy had been issued with a newer set of SOPs, but the team was unable to locate them, and so were not inspected. Some team members had not signed the document confirming they had read and understood the older SOPs and were unsure if they had read any of the newer SOPs.

The pharmacy had a process to record details of mistakes identified during the dispensing process, known as near misses. The team were aware of a paper-form near miss log they could use to record near misses, but the team could not locate the log and so, it was not inspected. Team members described how they were told by the responsible pharmacist (RP) or the pharmacy's accuracy checker if they had made a near miss. And they were required to rectify the mistake immediately. The team had implemented some changes to the way they worked in response to a pattern of near misses being identified. For example, the team had separated pregabalin tablets and capsules following a series of near misses. Additionally, team members had knowledge of common medicines that had similar packaging or names. And they ensured they took additional care when dispensing these medicines. A list of these medicines was displayed on a dispensary wall. The team had access to an electronic system to record and report details of dispensing incidents, which were identified after people had received their medicines. Details of such incidents were reported to the SI office. A member of the SI team then contacted the pharmacy to discuss the incident and any follow up actions to prevent a similar incident from recurring. The pharmacy's complaints procedure was clearly displayed via a notice affixed to a wall in the retail area. Any concerns or complaints were usually raised verbally with a team member. If the team member could not resolve the complaint, it was escalated to the RP on duty. Details of any complaints were recorded onto the electronic reporting system.

The pharmacy had current professional indemnity insurance. It displayed an RP notice which clearly outlined the name and GPhC registration number of the RP on duty. The RP record was generally completed correctly. However, on several days, the RP had not recorded the time when their RP duties ended. The pharmacy kept complete records of the private prescriptions it had dispensed. The pharmacy maintained complete CD registers. And of the sample checked, the team kept them in line with legal requirements. The team completed balance checks of the CDs against the physical quantity periodically. The recorded balance of a randomly selected CD was checked against physical stock. The quantity matched the pharmacy's records. The pharmacy kept a register of CDs that had been returned to the pharmacy for destruction.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The team placed confidential waste into a separate container to avoid a mix up with general waste. The waste was periodically securely destroyed. Team members understood the importance of securing people's private information. The RP had completed training on the safeguarding of vulnerable adults and children via the Centre of Pharmacy Postgraduate Education (CPPE). Several other team members, including the pharmacy's delivery driver had completed similar training courses and they were able to describe some common signs they would report. The delivery driver described several occasions where they had raised concerns with the team about the welfare of some elderly people who used the pharmacy. The pharmacy had a formal procedure to support team members in raising a safeguarding concern. Team members explained they would discuss any concerns they had with the RP.

Principle 2 - Staffing Standards not all met

Summary findings

Some team members are not actively undergoing training appropriate for their role in accordance with GPhC training requirements. And so, they carry out tasks for which they are not appropriately qualified or trained. Team members provide feedback on the pharmacy's services and implement change to help improve service delivery.

Inspector's evidence

On the day of the inspection the RP was the pharmacy's full-time pharmacist. They also had overall managerial responsibilities for the pharmacy. During the inspection they were being supported to manage the workload by four team members. One of the team members was a full-time accuracy checker and another was a full-time qualified dispenser. Two other team members were described as trainee dispensers. One of these team members dispensed medicines throughout the inspection. Neither of these team members had been enrolled onto approved qualification training.

Throughout the inspection, team members were observed working efficiently. Team members were supporting each other in completing various tasks. They could cover each other's absences by working additional hours if required.

The pharmacy didn't provide a formal training programme for its qualified team members. However, they maintained their knowledge and skills by reading pharmacy press material that was provided to the pharmacy periodically. Each team member received an annual appraisal. This was typically in the form of an informal one-to-one conversation between the team member and the RP. They discussed the team member's progress and areas of improvement. Team members explained how they would raise any concerns with the RP and felt comfortable providing feedback to help improve the pharmacy's services. Team members were aware of the presence of a whistleblowing policy to support them in raising anonymous concerns. They regularly held informal team meetings to discuss company news, workload management, feedback, and concerns. Team members were encouraged to discuss ways to improve the way the pharmacy operated. Recently, the team discussed the importance of ensuring the dispensary shelves were kept tidy and organised. Team members described how this had helped them reduce the risk of mistakes made during the dispensing process.

The team was set some targets to achieve by the pharmacy's owners. These included the number of prescriptions dispensed and retail sales. Team members felt the targets were often difficult to achieve. They ensured they focused on providing an efficient service to the local community.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are appropriately maintained and are suitable for the services the pharmacy provides. The pharmacy has the facilities for people to have private conversations with team members.

Inspector's evidence

The pharmacy premises were well maintained and kept clean. The dispensary was spacious and kept well organised throughout the inspection. The benches in the dispensary were well organised with baskets containing prescriptions and medicines awaiting a final check all stored in an orderly manner. There was a separate bench used by the RP to complete final checks of medicines. This helped reduce the risk of mistakes being made within the dispensing process. There was a staff room and several storerooms on the first floor. These rooms were kept tidy.

The pharmacy had sufficient space to store its medicines. Floor spaces in the dispensary were kept clear from obstruction which helped reduce the risk of a trip or fall. There was a small consultation room which was kept tidy and organised. There were some prescriptions and dispensed medication stored in the room. So people's names and address could be seen by anyone who used the room. Following a discussion with the RP, assurances were given that any confidential information would be removed from the consultation room following the inspection. The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Lighting was bright throughout most of the premises, however the stairs to the first floor were poorly lit and therefore there was a risk of a trip or a fall occurring.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy cannot always demonstrate that it stores its medicines requiring cold storage appropriately. This increases the risk of people being supplied medicines that are not fit for purpose. The pharmacy provides a range of services to help people improve their health. And it makes these services easily accessible to people. The services are generally well managed by team members, and they help support people to take their medicines correctly

Inspector's evidence

The pharmacy was accessible via a small step from the street to the main entrance door. There was a portable ramp for people to use if they had difficulty accessing the premises. For example, if they used wheelchairs or prams. The pharmacy clearly advertised its opening hours and the services offered. The pharmacy had the facility to provide large-print labels to people with a visual impairment. The RP spoke fluent Urdu and Punjabi and occasionally supported some people in these languages. Team members described how they supported people with a hearing impairment to access the pharmacy's services. This included providing written messages to people and speaking slowly. Team members were aware of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They were aware of recently issued legislation to ensure pharmacies supplied valproate in the original manufacturers packaging. The pharmacy had recently started providing the NHS Pharmacy First service. The pharmacy held the appropriate documentation to provide the service and all team members had undertaken training to support them in managing the service. The RP had access to supportive information including current patient group directions (PGDs), clinical pathways and the service specification to help support the safe delivery of the service.

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 hold prescriptions and medicines together which reduced the risk of them being mixed up. Prescriptions that were accuracy checked by the pharmacy's accuracy checker were clinically checked by the RP prior to the accuracy check being completed. However, the pharmacy didn't keep a record of the completion of a clinical check. And so, there was a risk that some medicines could be supplied to people without a clinical check of the prescription being completed. This risk was discussed with the team. The pharmacy sent some prescriptions to be dispensed off-site at a hub pharmacy. This process was designed to help reduce the team's dispensing workload. People were asked for permission for their prescriptions to be dispensed at the hub pharmacy. Team members entered data from these prescriptions onto an electronic system. The data was accuracy checked by the RP before being sent to the hub pharmacy. Dispensed medicines arrived at the pharmacy after approximately 48 hours.

The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. But the team didn't always use them. As a result, the pharmacy's electronic patient record was not always accurate. The pharmacy offered an optional delivery service and kept records of completed deliveries. The pharmacy supplied some people with medicines in multi-compartment compliance packs. The packs were designed to help people take their medicines correctly. The workload was spread over a four-week cycle. This helped keep the workload manageable. Team members kept master sheets which detailed the person's current medicines and administration time. They used these as a reference source to help them dispense the packs accurately. The original packs of medicines

were stored with the packs so the RP could check them with prescriptions to ensure the correct medicines had been picked. The packs were supplied with written descriptions of each medicine within the packs, which helped people easily identify them. However, the pack were not supplied with patient information leaflets for each medicine. And so, people were not provided with the full information about their medicines.

The pharmacy stored pharmacy-only (P) medicines behind the retail counter. The pharmacy had a process for team members to follow to check the expiry dates of the pharmacy's medicines every three months. The pharmacy held records to confirm when the process had been completed. No out-of-date medicines were found following a check of approximately 20 randomly selected medicines. Team members were observed checking the expiry dates of its medicines during the dispensing process. The pharmacy used two fridges to store medicines that required cold storage. The team didn't keep records of one of the fridge's operating temperature ranges. The thermometer of this fridge showed it was operating within of the accepted ranges of between 2 and 8 degrees Celsius. However, its maximum temperature recording was above the 8-degree Celsius limit. Drug alerts and recalls were received electronically by the team. Team members actioned the alerts and recalls as soon as possible and kept a record of the action taken.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the appropriately maintained equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

Inspector's evidence

The pharmacy used a range of CE marked measuring cylinders for preparing liquid medicines. There was suitable equipment to support the team to manage the NHS Pharmacy First service and to measure people's blood pressure. This included an otoscope and a digital blood pressure monitor. The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people could not 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.