General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 199 King Street, Hoyland, BARNSLEY, South Yorkshire, S74 9LJ

Pharmacy reference: 1039100

Type of pharmacy: Community

Date of inspection: 29/05/2019

Pharmacy context

This community pharmacy is in a residential area of the village of Hoyland, Barnsley. The pharmacy is open five days a week. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It also supplies medicines in multi-compartmental compliance packs to people living in their own homes. It provides a seasonal flu vaccination service. The pharmacy works with other local NHS healthcare professionals to provide a medicines management service. This helps people take their medicines appropriately.

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 met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	Although the exterior of the premises portrays a professional image, the pharmacy has untidy, dirty and cluttered areas that may impact on the ability of the pharmacy team to safely provide its services to people. It stores prescriptions awaiting checking and medicine stock on the floor and benches. This increases the risk of error and may be a trip hazard.
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 adequate processes and procedures, to help the team manage the risks to its services. And it generally manages the risks. It mostly keeps the records it must by law. The pharmacy generally keeps people's private information safe. It has adequate processes available to its team members, to help protect the welfare of vulnerable people. The pharmacy advertises how people can provide feedback and raise concerns. But the pharmacy team members cannot demonstrate how they have used the feedback to improve its services. The pharmacy team members record some of the errors that happen with dispensing. And they discuss their learning. They sometimes use this information to make changes to help prevent similar mistakes happening again. But, they don't always record all the details of why errors happen. So, they may miss out on learning opportunities.

Inspector's evidence

The pharmacy dispensary appeared busy at the time of the inspection. There were many baskets containing medicines on the benches and on the floor. These medicines were waiting for a final accuracy check. Medicines that had recently been delivered from a wholesaler, were also kept on the benches.

The pharmacy had a set of standard operating procedures (SOPs). These procedures were set to be reviewed every two years. This ensured that they were still relevant and up to date. The SOPs covered procedures such as taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The SOPs documented who was responsible for performing each task. The team members said they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with. And they had all signed the SOPs. Which indicated that they had read and understood the contents.

A process was in place to report and record near miss errors that were made while dispensing. The pharmacist or the accuracy checking technician (ACT) typically spotted the error and then made the team member aware of it. And then asked them to rectify it. A log was used to record details of the errors. The entries were made by the pharmacist or the ACT. The team discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. The team members did not record every error made. They said that they were often too busy to do so. No errors were recorded between February and May 2019. So, they may have missed out on improving the safety of their dispensing. The regular pharmacist analysed the near misses that were recorded each month. And the findings were documented and discussed with the team. The pharmacy had separated medicines with similar names and packaging to help prevent mistakes when selecting medicines. And, the pharmacist had given the team a briefing about common look alike and sound alike medicines to be aware of. The pharmacy had a process in place to record, report and analyse dispensing errors that had been given out to people. The team recorded the details of the errors on to an electronic reporting form and the form was sent to the superintendent pharmacist's team. The form was printed and filed for future reference.

The pharmacy had a notice in the retail area which detailed how people could make a complaint. The

pharmacy obtained feedback from people who used the pharmacy, through a community pharmacy questionnaire. The results of the 2018 survey was displayed in the retail area. And so, the information may have been out of date. The team members were unable to give any examples of how they used feedback to improve the services offered.

The pharmacy had up to date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. The responsible pharmacists did not always record the times that their duties ended. This is not in line with requirements. A sample of controlled drug (CD) registers were looked at and entries were being made in chronological order. Some pages in the register did not have completed headers. This is not in line with requirements. Running balances were maintained and audited every month. A random CD item was balance checked and verified with the running balance in the register (MST 10mg X 60). A CD destruction register was maintained to record patient returned medicines. And it was complete and up to date. The pharmacy kept private prescription records in a register, which was complete and in order. The pharmacy had not supplied any medicines in an emergency. And so, no records were available for inspection. It recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy had an information governance (IG) policy in place. It contained information on how the team should protect people's information and data. The team members were clear about the importance of protecting the confidentiality of the people they provided services to. They were trained on how to handle people's private information and had a working knowledge of data protection requirements and General Data Protection Regulation (GDPR). A privacy policy was on display in the retail area. The pharmacy stored confidential waste in a separate area of the dispensary. The waste was then shredded. The pharmacy stored some completed MUR consultation forms in the consultation room. And so, this information could be seen by people who used the room.

The pharmacist on duty and the ACT had completed training on safeguarding the welfare of vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). Other team members had not received training. The team members gave several examples of symptoms that would raise their concerns. The team had access to the local safeguarding board’s contact details. The pharmacy had guidance documents available for the team. But, there was no detailed procedure about what to do in the event of a concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the right skills and qualifications to undertake the tasks within their roles. The pharmacy supports its team members to complete training. And this helps them improve their knowledge and skills. The pharmacy's team members can give feedback and suggest ways to improve the pharmacy's services. And they can demonstrate how they have successfully implemented suggestions to provide an improved service.

Inspector's evidence

At the time of the inspection, the team members present were the full-time resident pharmacist, a full-time trainee pharmacy technician, a full-time accuracy checking technician (ACT) and two full-time pharmacy assistants. Other team members who were not present included two part-time pharmacy assistants, an ACT and a deliver driver. The team members often worked overtime to cover both planned and unplanned absences. They were not permitted to take time off in December, as this was the pharmacy's busiest period. One of the ACTs was also the pharmacy supervisor and took on many of the administrative responsibilities. Such as organising the staff rotas.

The pharmacist supervised the team members. 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. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team was aware of what could and could not happen in the responsible pharmacists' absence.

The pharmacy did not provide all its team members with a structured plan for ongoing learning. But it supported them to undertake training by giving them time to read trade press material sent to the pharmacy. They could tailor their learning to their needs. The trainee pharmacy technician said she recently asked for additional time to complete her training during the working day. And she was granted 2 hours a week of protected training time.

The team members attended a team meeting which was held every 1-2 months. The meetings were an opportunity for the team to give feedback and suggest ways they could improve the service. They discussed patient safety and talked about any errors openly and honestly. They could suggest ways to make improvements to the service provided. The team explained that they had recently introduced progress charts to assist them when dispensing medicines in multi-compartmental compliance packs. The team recorded on the charts, when the prescription had been issued, when it had been labelled, when it had been dispensed and when it had been subjected to a final accuracy check. The team said that the charts helped them monitor progress and improved their efficiency.

The team members received a performance appraisal each year with the pharmacy's supervisor. The appraisals were an opportunity for the team member to discuss what they enjoyed about their job and what they wanted to achieve in the future. They were set goals to achieve by the time the next appraisal took place.

The team members confirmed that they were able to discuss any professional concerns with the pharmacist. And they were aware of how they could raise concerns externally if they required. A

whistleblowing policy was in place. So, team members could raise a concern anonymously. The pharmacy set the team some targets to achieve. These included NHS prescription items and MUR consultations. The team said that they did not feel any pressure to achieve the targets.

Principle 3 - Premises **Standards not all met**

Summary findings

The dispensary is cluttered and untidy. And this may increase the risk of a dispensing error happening. The outside of the premises portrays a professional image but some areas of the pharmacy premises are not clean and in a poor state of repair. The pharmacy has a suitable room where people can speak to the pharmacy team members privately.

Inspector's evidence

The retail area of the pharmacy did not appear hygienic or clean. The shelves which held medicines were dusty and the carpet in the retail area was dirty. The dispensary area was untidy with various miscellaneous items stored on the dispensary benches. And so, there was less space for the team to dispense. The floor spaces of the dispensary were cluttered with several baskets which held prescriptions and medicines awaiting a final check. And so, there was a risk that other medicines may fall into these baskets leading to a dispensing error. Most medicines were stored on the dispensary shelves. But due to a lack of space some medicines were stored on the floor. The first floor of the premises contained stock rooms and staff kitchen and toilet facilities. The first floor was in a poor state of repair. Several walls had cracked and peeling plaster. Some floor boards were not properly secured. And so, presented a trip hazard. The pharmacy also had a cellar. But it was not accessed during the inspection as no medicinal stock was stored there.

There was a clean, well maintained sink in the dispensary used for medicines preparation and staff use. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing.

The pharmacy had a sound proofed consultation room which contained adequate seating facilities.

The lighting was bright, and the temperature was comfortable throughout inspection. The exterior of the premises portrayed a professional image.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. And it provides a range of services to meet people's health needs. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines and to identify what they look like. The team members take some steps to identify people taking high-risk medicines. And they provide them with advice to help them take their medicines safely. The pharmacy sources and stores its medicines appropriately. But the team doesn't remove all medicines from the shelves before the expiry date. And so it cannot be sure all its medicines are fit for purpose.

Inspector's evidence

The pharmacy was accessible via stepped access from the street. A ramp was not available. But a push button bell was affixed next to the entrance door. And it could be used to gain the attention of the team if a person needed assistance accessing the premises. But the bell was not working. The pharmacy advertised the services it offered via a display in the front window. It provided seating for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. Several healthcare related posters were displayed in the retail area.

The team members attached stickers to the prescriptions during the dispensing process to alert the pharmacist during checking of any issues, interactions or new medicines. And this also alerted team members during the hand out process, for example to the presence of a controlled drug or fridge line. The pharmacy had an audit trail for dispensed medication. The team achieved this by using dispensed by and checked by signatures on dispensing labels. The team members used separate areas to undertake the dispensing and checking parts of the dispensing process. They used baskets to keep prescriptions and medicines together. This helped prevent people’s prescriptions from getting mixed up. But the cluttered benches may of increased the risk of errors occurring in the dispensing process as items could become mixed between baskets or items could fall into baskets awaiting checking.

The team identified people who were prescribed high-risk medication such as warfarin using alert stickers. And they were given additional verbal counselling by the pharmacist, if the pharmacist felt there was a need to do so. But details of these conversations were not recorded on people’s medication records. So, the pharmacy could not demonstrate how often these checks took place. The pharmacy did not always assess the INR level. The team knew about the pregnancy prevention programme for people who were prescribed valproate. The team said that they knew about the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to information cards about the programme that they could provide to people. The team had not completed an audit to identify people that they regularly supplied valproate to. The pharmacy used clear bags to store dispensed fridge and CD items. This allowed the team to do another visual check before the handed the medicine to the person. And they asked the person collecting to also check the item to ensure they were receiving the medicine they were expecting.

The pharmacy was commissioned to provide a medicines management service. The pharmacist had completed the appropriate training to provide the service. The pharmacy was often sent information about people who may benefit from the service from healthcare providers such as district nurses. The pharmacist was required to assess the referral and create a medicines management care plan for the person. The plan was designed to help the person take their medicines more effectively. The pharmacist said he always visited the person and assessed any risks that may prevent them taking their medicines properly. The plan was then submitted back to the healthcare provider who made the referral. The pharmacist said that he enjoyed carrying out the assessments and occasionally suggested changes such as requesting that the person be provided with their medicines dispensed into a multi-compartmental compliance pack.

The pharmacy supplied over 400 people with multi-compartmental compliance packs. Many of these people were referred to the pharmacy from other local Cohen's branches. The team were responsible for ordering the person's prescription. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team used charts to record the progress of the dispensing. For example, when the prescription was ordered, when it had been labelled and when it had been dispensed. The team queried any discrepancies with the person's prescriber. The team recorded details of any changes, such as dosage increases and decreases, on the master sheets. The team supplied the packs with backing sheets which contained dispensing labels and information which would help people visually identify the medicines. The team supplied patient information leaflets to people each month as required by law.

The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. The pharmacy supplied people with a note when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy gave people owing slips when it 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 stored pharmacy only medicines behind the retail counter. These medicines could only be sold in a pharmacy, and under the supervision of a pharmacist. The storage arrangement prevented people from self-selecting these medicines.

The team checked the expiry dates of stock every three months and the team kept a record of the activity. The records were complete.
But, two out of date medicines were found following a random check of the dispensary stock. So, the team had missed these when checking. The team used alert stickers to highlight any stock that was expiring in the next 6 months. The pharmacy did not record the date of opening on liquid medication that had a short-shelf life once opened. And so, the pharmacy could not be certain that these medicines were still fit for purpose. 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). But the pharmacy did have software and installed scanners to assist the team to comply with the directive. The team had not received any training on how to follow the directive.

The team used digital thermometers to record fridge temperatures each day. A sample of the records evidenced temperatures were within the correct range.

The pharmacy obtained medicines from several reputable sources. It received drug alerts via email and the team actioned them. The pharmacy kept records of the action taken after the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment and facilities the pharmacy uses in the delivery of services are clean, safe and protect people’s confidentiality.

Inspector's evidence

The pharmacy had several reference sources available. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children.

The pharmacy used a range of CE quality marked measuring cylinders. And it had tweezers and rollers available to assist in the dispensing of multi-compartmental compliance packs. The medical fridge was of an appropriate size. The medicines inside were well organised.

The computers were password protected and access to people's records was restricted by the NHS smart card system. And computer screens were adequately positioned to ensure confidential information wasn’t on view to the public. The computers were password protected. Cordless phones assisted in undertaking confidential conversations.

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.