General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 16-18 Market Street, Hoyland, BARNSLEY, South Yorkshire, S74 9QR

Pharmacy reference: 1039105

Type of pharmacy: Community

Date of inspection: 25/04/2019

Pharmacy context

This is a community pharmacy on a parade with other small shops in the residential village of Hoyland in Barnsley, South Yorkshire. The pharmacy premises contains a post office. The pharmacy is open for 100 hours a week. 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 offers services including medicines use reviews (MURs), flu vaccinations 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

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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	2.2	Good practice	The pharmacy supports its team members to complete training. And this helps them to improve their knowledge and skills. They can tailor their training to their own needs.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The team are good at managing risks associated with the pharmacy's services such as dispensing. It has good processes in place for the supply of medicines in devices designed to help people remember to take them. And the team takes extra care with the supply of high-risk medicines to people. So, it can help people to take their medicines safely.
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, so the team can manage the risks to its services. And it keeps the records it must by law. 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 generally keeps people's private information safe. It has adequate processes available to its team members, to help protect the welfare of vulnerable people. And the pharmacy team members know what to do if they have a safeguarding concern. The pharmacy's team members record errors that happen with dispensing. And they discuss their learning. They sometimes use this information to learn and 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 had a set of standard operating procedures (SOPs) in place. These provided the team with information on how to perform tasks supporting the delivery of services. The SOPs covered procedures such as taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The team members were in the process of reading and understanding current SOPs. And they were expected to complete this task within the next few weeks. The pharmacy defined the roles of the pharmacy team members in each SOP. The SOP showed who was responsible for performing each task. Pharmacy team members reported they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy had a process in place to report and record errors that were made while dispensing. The pharmacist typically spotted the error and then let the team member know they had made an error. But the pharmacist did not give specific details of the error. So, the team member identified their own error, which helped with their learning. The team members were encouraged to record details of their own errors on to a log. But the pharmacist often made the record. The records included the time and date of the error. But the team didn't regularly record the causes of the errors. The error logs were analysed each month either by a dispenser or one of the two regular pharmacists. This was done to see if there were any patterns or common trends in the errors. Details of the analysis were documented and filed. And sent to the company's head office. The team discussed the findings of the analysis each month in a team meeting. The team had recently discussed the similar looking packaging of omeprazole and fluoxetine. The team members also regularly separated medicines after a series of errors had been made. And they attached stickers to shelves in front of medicines that had been involved in a mistake to highlight the risks when dispensing. The pharmacy recorded details of dispensing incidents electronically. The team printed off the record for future reference. And the mistakes were reported to the superintendent pharmacist. The team had made a recent error where they did not put the correct instructions on a label. The team did a root cause analysis. And they realised that the error was due to a team member not correctly reading the instructions put on the prescription by the doctor. The prescription was hand-written which caused the team member some difficulty in reading it. The team discussed the incident during a meeting. The team members were told to ask another team member to read any hand-written prescription to confirm the instructions before dispensing.

The pharmacy had a notice attached to a wall in the retail area which contained information on how to

make a complaint. The pharmacy organised an annual survey to establish what people thought about the service they received. The results of a survey from 2018 was displayed on a wall in the retail area. But they could not give an example of how they had improved the services they offered after feedback that had been received.

Appropriate professional indemnity insurance facilities were in place.
The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements.

A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries made in chronological order. Running balances were maintained. And they were checked every week. A random CD item was balance checked and verified with the running balance in the register (Fentanyl 200mcg buccal tablets X 42). A CD destruction register for patient returned medicines was correctly completed. The pharmacy maintained complete records for private prescription and emergency supplies. The pharmacy retained completed certificate of conformities following the supply of an unlicensed medicine.

The team held records containing personal identifiable information in staff only areas of the pharmacy. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. 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 on view to the public. The computers were password protected. All the team members had signed confidentiality agreements. The staff members who worked in the post office were separate from the pharmacy team. But they were able to access areas of the pharmacy which contained people's confidential information. E.g. a stock room on the first floor. There was no evidence that the post office team members had signed a confidentiality agreement or had completed any training on information governance.

The two regular pharmacists had completed training via the Centre for Pharmacy Postgraduate Education (CPPE) on safeguarding the welfare of vulnerable people. All other team members were 'dementia friends' trained. The team members gave several examples of symptoms that would raise their concerns. And they informed the inspector they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The contact details of the local children social care department were displayed on a wall in the dispensary. But the team did not have a guide or any other documentation available to them which guided them on how to manage or report 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. And they manage the workload well. The pharmacy is good at supporting its team members to complete training. And this helps them improve their knowledge and skills. They tailor their training to their own needs.

Inspector's evidence

One of the two regular pharmacists was on duty at the time of the inspection. And supported by one part-time and one full-time NVQ2 qualified pharmacy assistant, and a full-time accuracy checking technician (ACT). The other regular pharmacist, two full-time NVQ2 qualified pharmacy assistants, two part-time counter assistants, a delivery driver and a part-time trainee counter assistant were not present during the inspection. The two pharmacists both worked 40 hours a week, with the remaining 20 hours covered by locum pharmacists. The locum pharmacists who worked on Saturdays and Sundays were regular locums and had been working at the pharmacy for several months.

The team were observed supporting each other during the inspection and managing the workload well. And it used a communications diary to relay messages to each other. Examples included if a person prescription needed to be ordered urgently. The two pharmacists organised a few hours during the week when they worked alongside each other. This time was used for them to discuss staff rotas, analyse the error logs and manage other administrative tasks. The team members were able to work overtime to cover any planned or unplanned absences. The pharmacy could also ask for cover from staff from other local branches in the event of an emergency.

The pharmacist on duty 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 members accurately described the tasks that they could and could not perform in the pharmacist’s absence.

The team members were actively encouraged to continue ongoing learning. The team members completed learning about pharmacy related topics such as medicines and health conditions through reading trade press materials and discussing the topics with colleagues. All team members had recently completed training on oral health via the Centre for Pharmacy Postgraduate Education. A pharmacy assistant said that she had ample opportunity to train during quieter periods of business due to the extended opening hours. And the assistant was able to tailor her training as she wished. For example, the assistant had recently asked for additional training on the legality of CD prescriptions. The assistant received several one-to-one training sessions with one of the regular pharmacists. The assistant felt that she was supported well to help her achieve her goal.

The team members received a performance review with their line manager every six months. The reviews were designed to allow them to give feedback on how to improve the pharmacy's service, discuss various aspects of their performance, including what they had done well and what could be improved. And any learning needs were identified during these reviews. All team members had

received a recent appraisal. At her last appraisal she discussed how she could get some support after achieving a low score in an assessment after she had completed a training module. The assistant said that she was given extra support and time to train to help her achieve a better result when she attempted the assessment for a second time.

The team members described how they would raise professional concerns. A whistleblowing policy was in place. So, the team members could raise a concern anonymously.

The team were asked to meet various targets. These included retail sales, prescription volume and the number of medicine use review (MUR) and New Medicines Service (NMS) consultations completed. The team members said that they did not feel under pressure to achieve the targets. And would only try to deliver a service if it was in the best interest of the person.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and is adequately maintained. The pharmacy has facilities which allows people to have private conversations.

Inspector's evidence

The pharmacy was professional in its appearance. And was generally clean, hygienic and well maintained. Floor spaces were clear with no trip hazards evident. 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 area was free of clutter.

The pharmacy had a signposted and sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. Temperature was comfortable throughout inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services that can help people to meet their health needs. The team is good at managing risks associated with its services such as dispensing. It has good processes in place for the supply of medicines in devices designed to help people remember to take them. And the team members take extra care with the supply of high-risk medicines to people. So, they can help people to take their medicines safely. The pharmacy has adequate processes in place to ensure that the medicines it supplies to people are fit for purpose. It obtains its medicines from reputable suppliers and stores them appropriately.

Inspector's evidence

The pharmacy could be accessed from the street through a push/pull door. The services on offer, and opening times were advertised in the front window. Seating was provided 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. A wide range of healthcare related leaflets were available for people to select and take away.

Stickers were attached to prescriptions to alert the team to provide advice or complete actions on hand out. For example, information about interactions or the presence of a fridge or a controlled drug that needed to be added to the bag. A ‘mobile number required’ alert sticker was also used. The team members felt it was important that they had the mobile numbers of the people they regularly dispensed prescriptions for. And this allowed them to contact people for various issues. Like letting them know that they prescription was ready. Or to remind them that it was time for them to order their next prescription. An audit trail was in place for dispensed medication using dispensed by and checked by signatures on labels.

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 to stop people’s prescriptions from getting mixed up. The team used different coloured baskets to indicate urgency and which prescriptions required delivery. The pharmacy had a procedure in place to highlight dispensed controlled drugs, that did not require safe custody. This helped the team ensure that the medicine could not be supplied to people after the prescription had expired. The pharmacy used clear bags to store dispensed fridge and CD items. Which allowed the team to do a further check of the item against the prescription. And by the person during the hand out process.

The team identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist. The details of these conversations were recorded on people’s medication records. INR levels were assessed. The team were aware of the pregnancy prevention programme for people who were prescribed valproate. The team said that they were aware of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to leaflets and alert cards which were about the programme. And they gave these to any people who would benefit from information about the programme. The team identified three regular people who they dispensed prescriptions to. And could have benefitted from information about

the programme. The pharmacist contacted each of these people. And invited them to attend a private consultation with him.

People could request multi-compartmental compliance packs. And these were supplied to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance, so it had ample time to manage any queries. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the person's prescriber. The team always checked with people if they required any items that they didn't supply in the packs. The team recorded details of any changes, such as dosage increases and decreases, on the master sheet. The team supplied the packs with backing sheets which contained dispensing labels. And these contained information which would help people visually identify the medicines. The team supplied patient information leaflets with the packs each month.

The pharmacy kept records of the delivery of medicines from the pharmacy to people in their homes. The records included a signature of receipt. A separate delivery sheet was used for controlled drugs. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

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 stored pharmacy (P) 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 the stock every three months. And the team kept records of the activity. The team used 'short dated' stickers to highlight medicines that were expiring in the next six months. The team recorded the date the pack was opened on liquid medicines. This allowed them to identify medicines that had a short-shelf life once they had been opened. And check that they were fit for purpose and safe to supply to 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). No software, scanners or an SOP were available to assist the team to comply with the directive. The team had not received any training on how to follow the directive.

The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned immediately. The alerts were printed and stored in a folder.

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

References sources were in place. 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. Tweezers and rollers were available to assist in the dispensing of multi-compartmental compliance packs. The fridges used to store medicines were of appropriate sizes. Medicines were organised in an orderly manner. The computers were password protected and access to peoples' records were restricted by the NHS smart card system. 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.