General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, Chapeltown Health Centre, Spencer Place, LEEDS, West Yorkshire, LS7 4BB

Pharmacy reference: 1039702

Type of pharmacy: Community

Date of inspection: 04/02/2020

Pharmacy context

The pharmacy is within a large health centre in a suburb of Leeds. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides emergency hormonal contraception (EHC). The pharmacy provides a supervised methadone consumption service. And a needle exchange service.

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	1.2	Good practice	The pharmacy team members act competently when errors happen. They record their errors and share them with each other. The team regularly reviews the errors made. And it uses this information to take appropriate action to help prevent similar mistakes happening again.
		1.4	Good practice	People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services.
2. Staff	Standards met	2.5	Good practice	The team members discuss and share ideas and they proactively identify improvements to the delivery of pharmacy services. The team members introduce processes to improve their efficiency and safety in the way they work.
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 team identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services. The team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members act competently when errors happen. They record their errors and share them with each other. The team regularly reviews the errors made. And it uses this information to take appropriate action to help prevent similar mistakes happening again. The pharmacy has appropriate arrangements to protect people's private information. And it keeps all the records it needs to by law.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The SOPs described the roles and responsibilities of the team. And each SOP listed the role in the team the SOP related to. All the team had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The signature sheets related to the team member's role, such as pharmacist or dispenser. The team members worked within their competencies and knew when to refer to the pharmacist. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not record what caused the error and the actions they had taken to prevent the error happening again. The pharmacist manager reviewed these records each month to spot patterns and make changes to processes. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. These were errors identified after the person had received their medicines. The pharmacist manager was planning to train all the team to complete the report to ensure it was done in time. The dispensing incident report included the actions taken by the team to prevent the same error happening again. The pharmacist printed off the report for reference and kept it with a copy of the prescription. After a dispensing incident involving the wrong type of inhaler the pharmacist manager had discussed this with the team. And made a note of the error on the person's electronic record to remind the team of the error. The pharmacist placed a sticker on the shelf holding the inhalers to prompt the team to take care when selecting these products.

The pharmacist manager undertook a monthly patient safety review and shared the results with the team members. A recent review highlighted that team members had labelled 1% hydrocortisone cream as the 0.1% strength. The pharmacist manager identified that the incorrect strength on the label could confuse people. And may lead to the team dispensing the incorrect product. The pharmacist manager checked the labelling system on the computer and found that the first strength of hydrocortisone listed was 0.1%. This pharmacist manager knew this strength was not prescribed as often as the 1% strength. So, changed the settings for the 1% strength to appear on top of the list. The review reported that since

this change there had been no labelling errors with hydrocortisone cream. The pharmacist manager also completed an annual patient safety report. The latest report stated that following several occasions when the pharmacy received short dated medicines the team were reminded to check the expiry dates of stock from the wholesaler. The report stated that team members were asked to complete one task before starting another to ensure they remained focused. The pharmacy had a poster listing common medicines that looked alike and sounded alike (LASA). This included medication such as atenolol and allopurinol. The poster reminded the team to take care when dispensing these medicines. And the pharmacist manager had added stickers to the shelves holding the LASA medicines pregabalin and gabapentin. To remind the team to check the product they had selected when dispensing.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And on a poster displayed in the retail area. The pharmacy had received comments from people about the efficiency of the service. And in response the team reviewed the information given to people using the repeat prescription service about when to collect their medicines. So, the team had time to receive and dispense the prescription. And the person was not kept waiting for their medicines. The team attached a large print notice on the pharmacy counter informing people of the timescale and asked people to place their requests a week before they ran out of their medicines. The team found that people read this information and many complied with the request from the team to order their medicines on time. The team gave people presenting at the pharmacy with their prescription the time it was taking to process the prescription. So, the person could decide to wait or call back.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist (RP) records looked at found that they met legal requirements. The team knew what activities could and could not take place in the absence of the RP. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training on 03 September 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The team responded well when safeguarding concerns arose. The delivery driver reported to the team any concerns they had about people they delivered medicines to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The team members support each other in their day-to-day work. They discuss and share ideas and they proactively identify improvements to the delivery of pharmacy services. The team members introduce processes to improve their efficiency and safety in the way they work. The pharmacy provides the team members with some opportunities to develop their knowledge. And it gives team members some feedback on their performance. So, they can keep their skills and knowledge up to date.

Inspector's evidence

The full-time pharmacist manager covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of a full-time trainee pharmacy technician who was close to finishing the course, two part-time qualified dispensers and a delivery driver. The pharmacy provided the trainee pharmacy technician with protected time to complete their training. The pharmacy provided some extra training for the team. But this was mostly regulatory training. The pharmacist manager was training team members to complete tasks to support the workload. Such as accessing internal emails to check for alerts about medicines and how to respond to these alerts.

The pharmacy did not provide formal performance reviews for the team. But the pharmacist manager gave the team members informal, in the moment, feedback. So, they had a chance to know how they were performing. The pharmacy usually held weekly team meetings. The pharmacist manager used the meetings to discuss recent issues and share information sent from Cohens Head office. If a team member could not attend the meeting the pharmacist manager spoke to the team member individually.

Team members could suggest changes to processes or new ideas of working. The team had addressed the issue of the GP team stating they had not received prescription requests from the pharmacy team. The pharmacy team now added to the record of prescription requests the name of the person from the GP team the request was given to. The team had moved baskets holding incomplete prescriptions to a section in the dispensary with more space. This was close to the area where the team unpacked the delivery of medicines from the wholesaler. So, the team could complete these prescriptions soon after receiving the medicines. The pharmacist manager was not under pressure to meet targets for pharmacy services. And offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. The pharmacy has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a large, sound proof consultation room. The team regularly used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides services that support people's health needs. The team members manage the pharmacy services well. They identify issues that may affect the safe and effective delivery of services. They act appropriately to minimise any risk and support people. The pharmacy team members keep records of prescription requests and deliveries made to people's home. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy from the health centre. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role. Some team members spoke languages such as Urdu which helped people to understand the information the team provided.

The pharmacy was part of a local service supporting people with their inhaler technique. The pharmacist manager and trainee pharmacy technician provided the service. The service included checking that the person used the correct technique when using their inhaler. The team found several people were not using their inhaler correctly and provided the person with guidance on how to use the inhaler. The needle exchange service involved people placing the used needle containers directly into a dedicated waste bin. So, the team had no direct contact with the containers. The pharmacist manager had contacted Forward Leeds for advice about offering the service after the team received abuse from some people using the service. Forward Leeds advised the team to set times for people to access the service and to vary the times each day. The team agreed this and displayed posters in the pharmacy informing people of the times the service was available. The pharmacy had up-to-date patient group directions (PGDs) for the supply of emergency hormonal contraception (EHC). The PGDs provided the pharmacist with the legal authority to supply the EHC. The service was popular, people were often referred to the pharmacy from the teams in the health centre.

The pharmacy provided multi-compartment compliance packs to help around 100 people take their medicines. The Cohen’s offsite dispensary dispensed most of the packs for the pharmacy. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. And kept a list of packs sent to the offsite dispensary each day. The team members used a notice board to show the week they were processing. And the tasks such as ordering prescriptions that were due. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The offsite dispensary asked for a week to dispense and return the packs to the pharmacy for supplying to the person. The pharmacy team arranged for the timescale to be a week and one day. So, the team had time to dispense any medicines that the offsite dispensary did not supply. The pharmacist completed a clinical check and an accuracy check of the prescription before it was sent to the offsite

dispensary. The system recorded the GPhC registration number of the pharmacist to identify who had completed both checks. And recorded information such as medicines with special storage requirements. So, the team at the offsite dispensary was aware and would only provide weekly packs if this was appropriate for the medicine. The pharmacy kept records of when a copy of the prescription was sent to the offsite dispensary. The records included the date the supply to the person was due and if the person collected their packs or the pharmacy delivered the packs. And if there were medicines not included in the packs such as inhalers that the team dispensed.

The team used a room to the side of the main dispensary, away from the distractions of the retail area, when dispensing the medication into the packs prepared at the pharmacy. The pharmacy team recorded the descriptions of the medicines in the packs. And it supplied the manufacturer's patient information leaflets. The offsite dispensary provided pictures of the medication in the packs. But it did not send the patient information leaflets. The team kept copies of patient information leaflets to send with the packs supplied from the offsite dispensary. The team stored completed packs in clear bags awaiting supply to the person. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items. The team used PharmOutcomes to query the dose of a medicine on the discharge summary. And had received a corrected version from the hospital team.

The team members provided a repeat prescription ordering service. People rang the pharmacy to request their prescriptions. The team accessed the person's electronic medication record (PMR) to select the medicines the person required and to print off the request form. This enabled the team to check the person was ordering their regular medicines. And to inform the person if the request was too early as the GP may not issue the prescription. The team usually ordered the prescriptions four days before supplying to the person. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team used a diary to record the date the prescriptions were due back from the GP team. The record included the number of medicines ordered. The team regularly checked the diary to identify missing medicines or prescriptions and chase them up with the GP teams. The pharmacy team placed stickers on prescription requests when the person urgently needed their medicines. So, the GP teams were aware of this. The GP team used the request form to write the reason why the prescription was not issued and returned the form to the pharmacy team. So, the pharmacy team could pass this on to the person when they presented at the pharmacy. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had completed checks to identify patients that met the PPP criteria. The checks revealed one person prescribed valproate who met the criteria. This person was not on a PPP. So, the pharmacist had referred the person to their GP, provided the person with the PPP information and recorded this on the person's PMR.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacist manager placed a notice in the dispensary to remind the team of the 28-day limit and the notice listed the CDs this applied to. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The team members initialled the bag label

to show they had checked that the name and address on the bag label matched the prescription. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was in February 2020. The team used a large yellow sticker to highlight medicines with a short expiry date. No out-of-date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of Cetirizine oral solution with six months use once opened had a sticker attached detailing the date of opening of 14 January 2020 and a use by date of 13 July 2020. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out of date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The CD cabinet was small so the pharmacy used labelled baskets to keep the CD stock tidy. And to enable the team to easily locate the CD when dispensing. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had scanning equipment to meet the requirements of the Falsified Medicines Directive (FMD). But the pharmacy computer system had not been upgraded to support this. The team did not know when this would happen. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and to protect people's private information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And it had a fridge to store medicines kept at these temperatures. The fridge had a glass door to enable the team to view stock without prolong opening of the door.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held 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.