

Registered pharmacy inspection report

Pharmacy Name: Coopers Chemists, 144-150 High Road,
Willesden Green, LONDON, NW10 2PB

Pharmacy reference: 1040677

Type of pharmacy: Community

Date of inspection: 16/01/2020

Pharmacy context

The pharmacy is located in a health centre in a mixed residential and commercial area in north west London. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. The pharmacy has healthy living status.

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	1.2	Good practice	The pharmacy team records and reviews its mistakes and can give examples of action taken to stop the same sort of mistakes happening again.
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's working practices are safe and effective. The pharmacy manages risk well and it has written procedures which tell staff how to complete tasks effectively. It keeps its records up to date so that medicines are supplied safely and legally. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. They understand their role in protecting vulnerable people and keeping people's information secure.

Inspector's evidence

Near misses were recorded and reviewed and the information was collated into an annual patient safety review (PSR). Training to reduce errors through 'Lookalike, soundalike' (LASA) medicines had been completed by the pharmacist. Stock was arranged neatly on the dispensary shelves and the pharmacist explained that the pharmacy team were gradually separating medicines stock by placing dividers between different medicines. This would tidy medicines stock and minimise items being put away in the wrong place. LASA medicines were separated and there were shelf labels composed of a mixture of lower- and upper-case letters. For instance, where clarithromycin and ciprofloxacin had been separated, the label would be 'claRITHromycin' to alert staff to the risk of a picking error due to a LASA medicine. Amitriptyline and amlodipine had been separated. Prednisolone and propranolol had been separated. Following a picking error, packs of one LASA medicine had been enclosed in a rubber band. LASA errors were identified and discussed with the pharmacy team. An alert was added to the patient medication record (PMR). An action point detailed appointing a sodium valproate champion in the pharmacy team to give at-risk people information on the pregnancy prevention plan (PPP).

Workflow: when a patient presented a prescription, one half of a numbered, duplicate ticket was given to the patient and the other half was retained by the pharmacy. At the point of transfer the numbered tickets were matched along with name and date of birth to ensure the prescription was not given to a person with a similar name. Baskets were in use to separate prescriptions and medicines during the dispensing process. Two people were involved in the dispensing and checking process and there were separate dispensing and checking areas. The pharmacist performed the clinical and final check of all prescriptions. An additional check was made when dispensing paediatric medicines. The dispensing audit trail was completed by staff to identify who dispensed and checked the prescription. Interactions between medicines for the same patient were shown to the pharmacist. The doctors sometimes added information relating to the prescription for the pharmacist to check on EMIS before transfer of the medicines to the patient. There was



a procedure for dealing with outstanding medication. The original prescription was retained, and an owing slip was issued to the patient. For 'manufacturer cannot supply' items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared on a rolling basis for a number of patients according to a matrix. The pharmacy managed prescription re-ordering on behalf of some patients. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid. A risk assessment was completed regarding the patient's health, care plan and whether there was a carer to assist the patient. There was a folder of information relating to compliance aid patients. Each patient's information was retained in a polythene sleeve and included a backing sheet, care plan and any discharge summaries following a hospital stay. The polythene sleeve was placed in a basket along with medicines and compliance aids during preparation and then returned to the folder when the compliance aids were complete. Labelling included a description to identify individual medicines but patient information leaflets (PILs) were not always supplied with each set of compliance aids. The pharmacist gave an assurance that moving forward, PILs would be supplied with each set of compliance aids.

Some high-risk medicines such as alendronate were supplied in the compliance aid in a separate compartment and the patient was counselled on how to take the medicine. Controlled drugs (CDs) were supplied in the compliance aids on a weekly basis and the dates of CD prescriptions were managed to ensure supply within the 28-day validity of the prescription. Levothyroxine and lansoprazole were supplied in a compliance aid in a separate compartment to ensure they were taken before other medication and 30 minutes before food.

The annual patient questionnaire was conducted. The practice leaflet required re-printing. The standard operating procedures (SOPs) were under review and included responsible pharmacist and complaints procedures. Staff training in recently updated SOPs was current. To protect patients receiving services, there was professional indemnity insurance in place provided by the NPA expiring 30 Nov 2020. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. Records for private prescriptions, emergency and special supplies were generally complete.

The CD registers were mostly complete. The balance of CDs was audited but not always weekly in line with the SOP. A random check of the actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. Invoice number and name of the supplier but not the address was recorded for receipt of CDs. Footnotes correcting entries were not always signed and dated. Patient returned CDs were recorded in the destruction register for patient returned CDs.



Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR). There was a privacy notice displayed and the Data Security and Protection toolkit had been completed. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly. There was a leaflet detailing 'How we look after and safeguard information'. Staff had undertaken safeguarding and dementia friends training. The pharmacists were accredited at level 2 in safeguarding training. The safeguarding policy was retained in the SOP folder.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team works well together and manages the workload within the pharmacy. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: four part-time pharmacists, one full-time dispenser, three part-time dispensers (one enrolled and two accredited with National Pharmacy Association (NPA)), one full-time medicines counter assistant (MCA) also trained as a dispenser, two part-time MCAs. The pharmacists' work hours overlapped at certain times of the day and the superintendent pharmacist (SI) was on the premises to complete administration along with another staff member who delivered medicines to patients at home.

The pharmacist organised a weekly update meeting for staff and there was a staff WhatsApp group to communicate. In line with the Pharmacy Quality Scheme (PQS) criteria, training had been completed in sepsis, reducing LASA errors, safeguarding and risk management. Near miss and clinical audits had been risk assessed. Staff had completed children's oral health training for quality payments. There was an annual appraisal to monitor staff performance and set objectives. Staff were free to provide feedback and had suggested inserting dividers to separate medicines stock, stocking Osteocare massage oils and organising a free assessment day, and trialling extended opening hours when the surgery changed its hours. Targets and incentives were not set.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the provision of its services. The pharmacy prevents people accessing the premises when it is closed to keep medicines and information safe.

Inspector's evidence

The pharmacy's premises were generally clean and tidy. There was extended seating in the public area for waiting patients. The consultation room was located to one side of the medicines counter and was locked when not in use. Patient privacy was protected. Lavatory and handwashing facilities were elsewhere in the health centre building and were hygienic. There was sufficient lighting and air conditioning.

Principle 4 - Services ✓ Standards met

Summary findings

People with different needs can access the pharmacy's services. The pharmacy gets its medicines from reputable sources to protect people from harm. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe to use. Pharmacy team members know what to do if any medicines or devices need to be returned to the suppliers. They make sure that people have all the information they need so that they can use their medicines in the right way. They also give advice to people about where they can get other support.

Inspector's evidence

There was wide level access to the pharmacy. A lift between street level and the health centre and pharmacy was available for wheelchair users. There was not a hearing loop. Large font labels could be printed to assist visually impaired people. People could point to a poster at the counter to identify themselves as either hearing or visually impaired. Staff could converse in Urdu, Gujarati and Hindi to assist patients whose first language was not English. Google translate was used if necessary. Patients were signposted to other local services such as the surgery for flu vaccinations, the walk-in centre or urgent care.

The pharmacist explained the procedure for supply of sodium valproate to people in the at-risk group. Information on the pregnancy prevention programme (PPP) would be explained. There was information to give to patients on PPP. The intervention was recorded on the PMR. The pharmacist appointed a valproate champion to give information to people in the at-risk group information on PPP. The pharmacist explained the procedure for supply of isotretinoin to people in the at-risk group. Isotretinoin should be prescribed by a specialist. The prescriber would be contacted regarding prescriptions for more than 30 days' supply of a CD. CD prescriptions were made up when needed and the date was noted to ensure supply within the 28-day validity period. Prescriptions for CDs were highlighted with CD stickers. Interventions were recorded on the PMR.

Prescriptions for high-risk medicines were highlighted with stickers including 'Speak to pharmacist' and fridge item to prompt counselling to people. The pharmacist said when supplying warfarin, people were asked for their record of INR along with blood test due dates. INR was recorded on the PMR. Advice was given about side effects of bruising and bleeding. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded about the weekly dose made up of methotrexate 2.5mg tablets, when to take folic acid and what to do if a dose of methotrexate was missed. People were



advised to seek medical advice if they developed an unexplained fever.

In line with PQS, an audit had been conducted to identify people for referral for prescription of a proton pump inhibitor (PPI) for gastric protection while taking non-steroidal anti-inflammatory drugs (NSAID) audit. Other audits included monitoring dates of last foot checks and retinopathy screening for diabetic people and use of inhalers in adult and paediatric asthma patients. Clinical audits included monitoring people taking rivaroxaban to check they had progressed from the initial loading dose of the medication and switching PPI for people prescribed clopidogrel. The healthy living health promotion displays increased public awareness and included information on 'step up and stay up' fall prevention, care when taking antibiotics to prevent developing antibiotic resistance, Stoptober, flu vaccination, sepsis, oral hygiene, stroke and dry January.

Medicines and medical devices were delivered outside the pharmacy. There was a delivery diary to record the delivery and a patient signature was recorded indicating a successful delivery. Medicines and medical devices were obtained from Alliance, AAH, Phoenix, Sigma and Colorama. Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and recorded on a rolling basis. No date-expired medicines were found in a random check. Liquid medicines were marked with the date of opening and medicines were stored in original manufacturer's packaging. Cold chain items were stored in the medical fridge. Uncollected prescriptions were cleared from retrieval after three months after contacting the patient. CD prescriptions were highlighted. Waste medicines were stored separate from other stock. Falsified medicines directive (FMD) hardware and software was operational at the time of the visit. Drug alerts were received, printed, actioned and filed.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

Current reference sources included BNF and BNF for children, Drug Tariff online and electronic reference sources via Proscript Connect. The dispensary sink required treatment to remove lime-scale. There were stamped measures to measure liquids. The medical fridge was in good working order. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinet was fixed with bolts. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly.

What do the summary findings for each principle mean?

✓ 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.