General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 209-211 Spendmore Lane, Coppull, CHORLEY, Lancashire, PR7 5BY

Pharmacy reference: 1075493

Type of pharmacy: Community

Date of inspection: 19/03/2024

Pharmacy context

This is a community pharmacy situated on a main road in the village of Coppull, near Chorley. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations, the NHS Pharmacy First service, and emergency hormonal contraception. The pharmacy supplies medicines in multi-compartment compliance packs to some people to help them take their medicines at the right time.

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	N/A	N/A	N/A
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 team follows written procedures, and this helps them to provide services in a safe and effective manner. The pharmacy keeps the records it needs to by law. And members of the team understand the need to keep people's private information safe. But they do not always record things that go wrong to help identify learning opportunities.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) available in a folder. These had been issued in February 2021 and their stated date of review was in February 2027. Members of the pharmacy team had signed a training record to say they had read and accepted the SOPs.

A process was in place when dispensing errors were identified, and a record of any learning outcomes were maintained. A paper log was available to record any near miss incidents. The pharmacist also completed a quarterly review of near miss records to identify underlying themes and learning opportunities. But mistakes had not been recorded since February 2024. So the pharmacy may not be able to identify contributing factors during this time as part of their review. The pharmacist explained that they had fallen behind with keeping this up to date. The pharmacist would highlight mistakes with individual team members so they could discuss and learn from them. The team had moved some medicines away from other to help remind them to take care when dispensing some medicines. For example, methotrexate was kept in a basket with a warning label attached, and anticoagulant medicines were stored in a dedicated drawer.

The roles and responsibilities for members of the team were documented on a matrix. A trainee dispenser was able to explain what their responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Members of the pharmacy team wore standard uniforms and had badges identifying their names and roles. The correct responsible pharmacist (RP) notice was on display. The pharmacy had a complaints procedure. Any complaints would be recorded and sent to the head office and followed up. A current certificate of professional indemnity insurance was seen.

Records for the RP, private prescriptions and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained. Running balances were recorded, but these were checked infrequently which meant that members of the team may not always be able to identify a discrepancy in a timely manner. Two random balances were checked, and both were found to be inaccurate. Following the inspection, the pharmacist confirmed he had corrected the erroneous records and corrected the balances to match the CD registers. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. Members of the pharmacy team had completed IG training. When questioned, a trainee dispenser was able to describe how confidential information was separated and destroyed using a shredder. A poster in the retail area explained how the pharmacy handled and stored people's information. Safeguarding procedures were included in the SOPs and members of the team had completed safeguarding training. The pharmacist had completed level 2 safeguarding training and understood where to find the contact details for the local safeguarding board.

A trainee dispenser said they would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload safely. And they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist, seven dispensers, two of whom were in training, and a medicine counter assistant (MCA). One of the dispensers was also trained to complete final accuracy checks. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be manageable. Staffing levels were maintained by a staggered holiday system. Relief team members could be requested from the head office if necessary.

Members of the pharmacy team completed some additional training. For example, they had recently completed a training pack about the NHS Pharmacy First service. Training records were kept showing what training had been completed. But further training was not provided in a formalised manner, which would help to make sure learning needs were met. A trainee dispenser gave examples of how they would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines they felt were inappropriate, and refer people to the pharmacist if needed. The pharmacist felt able to exercise their professional judgement and this was respected by members of the team.

Members of the team described a good level of support provided by the pharmacist and between each other. Team members were seen to work well together and were assisting each other with any queries they had. The team held regular huddles to discuss their ongoing work. The pharmacist provided ad hoc feedback to team members, but there was no formal appraisal programme. So, development needs may go unaddressed. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or contacting the head office. The pharmacy had targets for professional services such as the NHS New Medicines service. However, the pharmacist did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available for people to have a private conversation with a member of the team.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. People in the retail area were not able to view any patient sensitive information due to the position of the dispensary. The temperature was controlled using air conditioning units and lighting was sufficient. Team members had access to a kitchenette area and WC facilities.

A consultation room was available. It was tidy with a desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they safe to supply to people. The pharmacist provides counselling to people about their medicines to help make sure they are safe to use.

Inspector's evidence

The pharmacy was accessible for wheelchair users. There was also wheelchair access to the consultation room. Various posters provided information about the services offered and information was also available on the website. The pharmacy opening hours were displayed and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service, and delivery records were kept. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

Some prescriptions were dispensed by an automated system at the company's hub. This was a registered pharmacy which dispensed prescriptions for a number of pharmacy branches within the same company, and the dispensed medicines were delivered to the pharmacy to be supplied to people. Prescriptions for the hub were labelled electronically at the pharmacy by members of the team. The pharmacist then completed a clinical and accuracy check of the records. The information was then transmitted to the hub for the medicines to be dispensed. Some items could not be dispensed by the hub, including items out of stock, not stocked, or CD and fridge items. The process was auditable by use of a personal log in to identify who had labelled the prescription and who performed the accuracy check.

Dispensed medicines were received back from the hub within 24-48 hours. The medicines were packed in sealed clear bags with the patient's name and address the front. These did not need to be accuracy checked by the pharmacy unless they opened the bag, in which case the RP in the pharmacy was responsible for the final accuracy check. When the dispensed medicines were received in branch, they were matched up with the prescription forms, any other bags from the hub, and any medicines or medical devices that had been dispensed and checked locally in the pharmacy.

The pharmacy team initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels for medicines dispensed in the pharmacy. This helped to create an audit trail of the team members involved in the dispensing process. They used dispensing baskets to separate people's prescriptions to avoid medicines being mixed up. The baskets were colour coded to help prioritise dispensing. The pharmacist performed a clinical check of the prescriptions and then signed the prescription form to indicate this had been completed. When this had been done an accuracy checker was able to perform the final accuracy check. Dispensed medicines awaiting collection were kept on a shelf using an alphanumerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Members of the team were seen to confirm the patient's name and address when medicines were handed out.

Some medicines were dispensed in multi-compartment compliance packs. Before a person was started

on a compliance pack the pharmacist would complete an assessment about their suitability. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought and retained for future reference. The compliance packs were labelled with medication descriptions so that people could identify their medicines. But patient information leaflets (PILs) were not routinely supplied which meant people may not always have access to additional information.

Schedule 3 and 4 CDs were highlighted using a sticker so that team members could check the validity of the prescription at the time of supply. The pharmacist had completed an audit to identify people who were taking anticoagulant medicines to help make sure they had received counselling about taking their medicines safely. But other high-risk medicines (such as lithium and methotrexate) had not been audited in the same way. And they were not highlighted to remind team members to provide counselling. Which meant people taking these medicines may not recieve the additional advice they need to help make sure they are used safely. Team members were aware of the risks associated with the use of valproate containing medicines during pregnancy, and the need to dispense the original pack. Educational material was supplied when the medicines were dispensed. The pharmacist had spoken to patients who were at risk to make sure they were aware of the pregnancy prevention programme. But records of counselling were not always kept, which would help with the continuity of care.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Medicines were date checked every three months. A record of what medicine stock had been checked was kept as an audit trail. Short-dated stock was highlighted using a sticker. But liquid medicines, which may have a shorter shelf life once opened, did not always have the date of opening written on. For example, a bottle of oral morphine solution was open, and this expired within 90 days of opening. So, team members may not know whether the medicine remained fit for purpose.

Controlled drugs were stored appropriately in the CD cabinet, with clear separation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a thermometer. The minimum and maximum temperature was being recorded daily. Records for the last three months were checked and indicated the temperature had been in range. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

Team members had access to the internet for general information. This included access to the British National Formulary (BNF), BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were used for methadone to prevent cross contamination. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed team members to move to a private area if the phone call warranted privacy. The consultation room was used appropriately. People were offered its use when requesting advice or when counselling was required.

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.