General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, Apollo Court, High Street, Dodworth, BARNSLEY, South Yorkshire, S75 3RF

Pharmacy reference: 1085409

Type of pharmacy: Community

Date of inspection: 29/01/2020

Pharmacy context

This is a community pharmacy next to a GP surgery in the village of Dodworth, Barnsley. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the New Medicines Service, flu vaccinations and medicines use reviews. It supplies some medicines in multi-compartment compliance packs to people living in their own homes. And it provides a home delivery 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	1.4	Good practice	The pharmacy's team members are proactive in getting feedback from people who use the pharmacy. And they use the feedback well to improve the services the pharmacy provides.
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 identifies and manages the risks associated with the services it provides to people. And it has a set of up-to-date written procedures for the team members to follow. The pharmacy keeps most of the records it must have by law. And it keeps people's private information secure. The team members are proactive in getting feedback from people who use the pharmacy. And they use the feedback well to improve the services the pharmacy provides. The team members openly discuss and record any mistakes that they make when dispensing. So, they can learn from each other. They discuss how they can improve, and they make changes to minimise the risk of similar mistakes happening in the future. The team members know when and how to raise a concern to help safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had a relatively large retail area which led to the dispensary at the rear. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The retail area and the dispensary were open plan which allowed the team members to easily see into the retail area from the dispensary. The dispensary was set back far enough from the pharmacy counter to allow the team members to discuss confidential matters without being overheard by people in the retail area. The pharmacist used a bench closest to the pharmacy counter to complete final checks on prescriptions. And this allowed him to easily oversee any sales of medicines and listen to any advice the team members were giving to people. The pharmacy was busy at the time of the inspection with many people bringing their prescriptions in to be dispensed. And asking the pharmacy team for advice about their health.

The pharmacy had a set of written standard operating procedures (SOPs) in place. The SOPs had an index, which made it easy to find a specific SOP. The pharmacy's superintendent pharmacist's team reviewed the SOPs every two years. The SOPs were due for their next review in July 2020. They covered areas such as dispensing and the taking in of prescriptions. Each team member had read and understood the SOP that was relevant to their role. The team members had recently completed a SOP assessment which they had all passed. And certificates were seen. The assessment involved the team members completing a test of around 30 questions. They needed to achieve a minimum of 80% to pass the assessment.

The pharmacist and the pharmacy's accuracy checker highlighted near miss errors made by the team when dispensing. And they recorded the details of each near miss error onto a paper near miss log. The team members recorded the date, time and type of the error. But they did not record the reasons why the error may have happened in much detail. And so, they may have missed out on some learning opportunities. The team members said that their main reason for errors was because of a lack of concentration or rushing. But they did not investigate these reasons any further. A team member explained that she often told the team members working on the pharmacy counter, to increase waiting times if she felt she was rushing too much. This helped her slow down the dispensing process and ask another team member to double check her work if she was unsure. The pharmacist analysed the near miss records each month for any patterns and trends. And the team discussed any findings in a monthly patient safety briefing. The team agreed actions to complete following each analysis. And they assessed success of those actions at the next briefing. The pharmacy had recently discussed medicines that

sounded or looked alike (LASAs). And there was a poster in the dispensary which listed the most common ones. The team found many of the near miss errors involved incorrectly picking amlodipine 5mg tablets instead of 10mg tablets, and visa-versa. The reason for this was because both strengths were packaged in yellow boxes. To prevent similar errors happening again, the team decided to separate the two strengths from each other. The pharmacy had a process to record and report dispensing incidents that had reached the patient. It recorded the details of such incidents using an electronic reporting system. A sample of some records were seen. Within the sample the team had recorded the full details of the error, who had been involved, why the error might have happened and what the pharmacy did to prevent a similar error happening again. Most recently, the pharmacy had supplied a person with the incorrect quantity of a medicine. The team members discussed the incident during a patient safety briefing, and they considered ways they could prevent a similar incident happening again. They discussed making sure each split pack of a medicine was visually distinguishable from a full pack by using a marker to score each side of the packaging.

The pharmacy displayed the correct responsible pharmacist notice. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist. The accuracy was seen completing accuracy checks on prescriptions that had been clinically checked by the pharmacist. And she signed each prescription to indicate she had completed the accuracy check. The pharmacist also signed the prescription to indicate he had completed the clinical check.

The pharmacy had a formal complaints procedure in place. And details were available for people to see via a poster displayed in the retail area. The pharmacy collected feedback through an annual patient satisfaction questionnaire. There was a signposted box in the retail area for people to put their completed questionnaires into. The pharmacy analysed the first 100 questionnaires and the results of survey were displayed on a poster in the retail area. The team members said many people suggested the pharmacy provide free blood pressure checks. This was mainly because they had to often wait a few days to have their blood pressure checked at their GP surgeries. The pharmacy had always offered free blood pressure checks but they realised the service was not well promoted to the local community. The team members designed displays reminding people of the service. And put them in prominent positions in the retail area. Additionally, a team member completed some training on how to carry out the checks. And familiarised herself with guidance from the British Heart Foundation on when she might need to refer a person to their GP.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept CD registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock at least every two months. A physical balance check of a randomly selected CD matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy did not retain certificates of conformity for unlicensed medicines, which is not in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team was aware of the need to keep people's personal information confidential. And team members were seen offering the use of the consultation room to people or moving to a quieter area of the retail area, when discussing their health. They had all undertaken General Data Protection Regulation (GDPR) training. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate

bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor.

The pharmacist had completed training on safeguarding via the Centre for Pharmacy Postgraduate Education (CPPE). The other team members had not completed any formal training. When asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. The pharmacy assistant explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage or report a concern and the contact details of the local support teams. Recently, the team members had concerns about the ability of a vulnerable person to take their medicines correctly. The pharmacy started to supply the person's medicines in a multi-compartment compliance pack to help them remember to take their medicines correctly.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload and to ensure people receive a high-quality service. And they feel comfortable to raise professional concerns when necessary. The pharmacy supports its team members to complete regular training to help them keep their knowledge and skills refreshed and up to date. Particularly those who are enrolled on a training course.

Inspector's evidence

At the time of the inspection the responsible pharmacist was the pharmacy manager. He was also an area manager and managed around ten Cohens pharmacies. During the inspection he was supported by two full-time NVQ level two pharmacy assistants, a full-time accuracy checker, a full-time trainee pharmacy assistant and a pre-registration pharmacy graduate. The pharmacist worked four days a week. A part-time relief pharmacist covered his absences. The pharmacy had recently had a review of their staffing profile after a full-time dispenser had left the business. The pharmacy was currently recruiting for a replacement dispenser. The pharmacist felt he had enough team members to ensure the pharmacy provided a high quality of service. The team members were observed managing the workload well and had a manageable workflow. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. The team members did not work any additional hours to cover each other's absences as they felt they had enough team members to cope with the absences. Several team members occasionally went to help other Cohen's pharmacies when they were short-staffed. The team members did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The team members received training time on an ad-hoc basis. And they had some training records. They had recently trained on becoming 'dementia friends'. The team completed a quiz once they had completed the training. At the end of the test, they received the result and a certificate to say they had passed. The team members generally completed their training in the consultation room, and they received time to undertake this. The pre-registration trainee received an hour of protected training time per day. And she said she was well supported by the pharmacist and colleagues in helping her resolve any queries. For example, she had recently had some questions about dispensing a modified release form of a medicine. Another team member helped her complete the dispensing of the prescription and answered any questions she had. There was no formal process for the team to receive performance appraisals. But the team members received regular verbal feedback from the pharmacist on how they were performing and meetings targets. The team members attended regular team meetings where they could discuss ways and give feedback on how to improve the service they provided to people. A team member who had recently joined the pharmacy explained she felt the pharmacy could improve by ensuring they clearly marked any medicines that were dispensed in plain white cartons with the medicine's expiry date. The team implemented the suggestion.

The team members felt comfortable to raise professional concerns with pharmacist or the pharmacy's area manager. The pharmacy had a whistleblowing policy. And so, the team members could raise

concerns anonymously. The team was set various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and professional in its appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was spacious, and it was kept tidy and well organised during the inspection and the team used the bench space well to organise the workflow. Floor spaces were generally kept clear to minimise the risk of trips and falls. But there were some baskets on the floor which contained split packs of medicines. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation.

The pharmacy had a large sound-proofed consultation room with seats where people could sit down with the team member. The room was smart and professional in appearance and was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are easily accessible to people. The pharmacy manages its services appropriately and delivers them safely. It supports some people to take their medicines correctly by providing their medicines in multi-compartment compliance packs. And it suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately. The team members identify people taking high-risk medicines. And they support them to take their medicines safely and give them appropriate advice.

Inspector's evidence

The pharmacy had level access to two entrances. One from the street and one from the attached GP surgery. The entrance door from the street was power assisted. And so, people with prams and wheelchairs could enter the pharmacy unaided. The pharmacy advertised its services and opening hours in the main window and on the pharmacy's website. It stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. For example, leaflets about sepsis and coping with memory loss. The team had access to the internet to direct people to other healthcare services. The pharmacy could supply people with large print dispensing labels if needed.

The team members regularly used various alert stickers during dispensing, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. They used red baskets to identify any prescriptions for people who were waiting in the pharmacy. They used 'CD' stickers to keep with prescriptions. This system helped the team members check the date of issue of the prescription and helped prevent them from handing out any CDs to people after their prescription had expired. 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 pharmacy kept records of the delivery of medicines it made to people. But the records did not always have a signature of receipt. And so, a complete audit trail was not in place that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The pharmacy managed the workload across four weeks. The team was responsible for ordering people’s prescriptions. And this was done in the third week of the cycle. Which gave the team members a week to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs in a segregated part of the dispensary. This was to minimise distractions. And they kept all documents related to each person on the service in separate wallets. They kept the wallets in alphabetical order to make sure they were easy to find. The documents included master sheets which detailed the person's current medication and times of administration. The team members used these to

check off prescriptions and confirm they were accurate. The team members held all prescriptions, documents and stock in separate baskets during the dispensing process. And they used shelves on the first floor of the premises to store the baskets. The team members recorded details of conversations they had with people's GPs. For example, if they were notified of a change in directions, or if a treatment was to be stopped. They supplied the packs with information which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. And they used alert stickers which they attached to dispensed medicine bags as a reminder to discuss the person's treatment when handing out the medicine. The pharmacist asked the person collecting the medicines various questions to make sure they were taking their medicines safely. For example, the pharmacist asked for the person's current and target INR, their daily dosage and the date of their next blood test. The pharmacist recorded the INR levels on the person's electronic medication record (PMR). The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No one had been identified.

The pharmacy provided a popular flu-vaccination service. It had completed over 150 vaccinations in the 2019-2020 season. The pharmacist had certificates which showed he had the relevant training to provide the service. And an up-to-date patient group direction (PGD) was seen. The pharmacist completed all vaccinations in the consultation room and had various items readily available to help him administer the vaccinations safely. These included adrenaline pens, a sharps bin, gloves, plasters and alcohol hand gel.

Pharmacy medicines (P) were stored behind the pharmacy counter to prevent people self-selecting them. The pharmacy stored its medicines in the dispensary tidily. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next six months. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD denaturing kits.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had not received any training on how to follow the directive. But they had the correct scanners installed. The team members were unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinet was secured and of an appropriate size. The medicines inside the fridge and CD cabinet were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team members used tweezers and rollers to help dispense multi-compartment compliance packs. A blood pressure machine was kept in the consultation room. And it was calibrated every year. But the pharmacy did not keep any records of this. The fridges used to store medicines were of an appropriate size.

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 seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people 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.