General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, Rooley Lane, BRADFORD, West Yorkshire, BD4 7SS

Pharmacy reference: 1089324

Type of pharmacy: Community

Date of inspection: 12/06/2024

Pharmacy context

The pharmacy is adjacent to a health centre in the suburbs of Bradford. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide other healthcare services including the NHS Pharmacy First Service. And they deliver medicines to people's homes.

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 adequately identifies and manages risks. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. The pharmacy has most written procedures it needs relevant to its services to help team members provide services safely. Team members record and discuss the mistakes they make so that they can learn from them. But they don't always capture key information, so they may miss some opportunities to learn and improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage risks. The superintendent pharmacist (SI) had reviewed the SOPs in 2022, and they were due to review them again in 2024. Pharmacy team members had signed to confirm they had read and understood the SOPs. The pharmacy received regular bulletins from the company's head office, which communicated key topics and information for the team to consider. A recent example was a bulletin containing information regarding the upcoming implementation of a new electronic controlled drug (CD) register system.

The pharmacy provided the NHS Pharmacy First service to people. Pharmacy team members explained how the pharmacy had considered some of the risks of providing the service, such as the suitability of the pharmacy's consultation room to deliver the service from. And ensured they had stock of the relevant medicines and the availability of the necessary equipment. They also completed the necessary training and had the correct SOPs and supporting documents in place. Team members had an aide memoir which they used when making referrals to the pharmacist. The locum pharmacist had their own record of competence to provide the service, which gave details of training they had completed.

Pharmacy team members highlighted and recorded mistakes identified before people received their medicines, known as near misses. There were documented procedures to help them do this effectively. They used an electronic system to upload information about mistakes to head office. Pharmacy team members discussed mistakes and why they might have happened. And they gave some examples of changes they had made to help prevent isolated near miss errors from happening again, such as separating different strengths of amlodipine and atorvastatin. Team members rarely captured specific information about why the mistakes had been made. Or the changes they had made to prevent a recurrence and to help aid future reflection and learning. And they did not regularly analyse the data to establish patterns of mistakes. So, they may miss opportunities to learn and make improvements. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. The records available gave a clear explanation of the error. But these records also did not capture information about causes to help team members make the most effective adjustments to improve safety.

The pharmacy had a documented procedure for handling complaints and feedback from people. Pharmacy team members explained people usually provided verbal feedback. There was a poster available for people in the retail area about how to provide the pharmacy with feedback. The pharmacy had current professional indemnity insurance in place.

The pharmacy kept accurate CD registers and maintained running balances for all registers. Pharmacy team members audited these balances every month. Checks of the running balances against the physical stock for three products were found to be correct. The pharmacy kept a register of CDs returned by people for destruction. It maintained a responsible pharmacist record electronically, and it was complete and up to date. The pharmacist displayed their responsible pharmacist notice. Pharmacy team members monitored and recorded fridge temperatures. The pharmacy kept complete private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. The bags were sealed when full and collected approximately monthly by the company's head office for secure destruction. Pharmacy team members explained how important it was to protect people's privacy and how they would protect confidentiality.

Pharmacy team members gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would discuss their concerns with the pharmacist, area manager and head office colleagues if necessary. Team members were also aware of how to find information about key local safeguarding contacts by using the internet. Team members were unable to find the pharmacy's safeguarding procedure during the inspection. They explained they had previously completed safeguarding training, but they could not remember when and they did not have any records of their training available.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete training to help keep their knowledge and skills up to date. Pharmacy team members feel comfortable raising concerns and discussing ways to improve services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist and two qualified dispensers. Team members completed some training modules ad hoc when asked to by head office. They did not receive a regular appraisal with a manager. And they explained how they would raise any learning needs informally with the pharmacist or head office colleagues, who would signpost them to relevant resources.

Pharmacy team members explained how they would raise professional concerns with the pharmacist, area manager or head office. They felt comfortable sharing ideas to improve the pharmacy or raising a concern. And they were confident that their concerns would be considered, and changes would be made where they were needed. The pharmacy had a formal whistleblowing policy. And pharmacy team members were aware of how to access the process to report concerns anonymously.

Team members communicated with an open working dialogue during the inspection. They felt comfortable making suggestions to improve their ways of working. They explained how they had recently changed the way they delegated roles and responsibilities amongst the team for various key tasks. And their new system was working well to ensure these tasks were completed on time. The pharmacy asked team members to achieve various targets, mainly relating to the services they provided to people. The pharmacy received regular progress updates from their area manager. And the team were supported to meet their targets by head office colleagues.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides. The pharmacy has a consultation room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. Its floors and passageways were free from clutter and obstruction. And it kept equipment and stock on shelves throughout the secure premises. The pharmacy had a consultation room, which was clearly signposted, and pharmacy team members used the room to deliver some services and have private conversations with people. There was a clean, well-maintained sink in the pharmacy, which team members used for medicines preparation. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy kept heating and lighting to acceptable levels.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely and effectively. The pharmacy suitably sources its medicines. It stores and manages its medicines appropriately. And it has some processes to help people understand and manage the risks of taking higher-risk medicines. But team members don't always provide people with the necessary printed information to help them manage taking their medicines properly.

Inspector's evidence

The pharmacy had level access from the health centre car park. Pharmacy team members could provide large-print labels and instruction sheets to help people with a visual impairment access services. And they would use written communication to help people with a hearing impairment.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This maintained an audit trail of the people involved in the dispensing process. They used baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy delivered some medicines to people. It recorded the deliveries it made. The delivery driver left a card through the letterbox if someone was not at home when they attempted delivery. The card asked people to contact the pharmacy. People were asked to sign to confirm receipt of specific CDs.

The pharmacist counselled people receiving prescriptions for valproate when appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if the person was on a Pregnancy Prevention Programme. The pharmacy had printed materials available to provide to people to help them manage the risks of taking valproate. Team members were aware of the requirements to dispense valproate in manufacturer's original packs.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of medicines on the backing sheets, so they could be identified in the pack. Team members documented any changes to people's medication on the person's electronic patient medication record (PMR). The pharmacy had some of its multi-compartment compliance packs dispensed at the company's off-site dispensing hub pharmacy, where medicines were picked and assembled using automation. Pharmacy team members explained that prescriptions were assessed to establish whether they were suitable to be sent to the hub pharmacy. The pharmacist performed a clinical and accuracy check of each prescription. Once the pharmacist authorised the prescription, it was sent to the hub pharmacy for assembly. The pharmacy received the medicines in sealed packages from the hub pharmacy. Pharmacy team members matched the packages with the relevant printed prescriptions. And these were placed on the prescription retrieval shelves ready for collection or delivery. The packs provided by the hub pharmacy had backing sheets to the packs, providing people had written instructions of how to take their medicines. And these included pictures of each medicine so they could be identified in the pack. The pharmacy did not routinely provide people with patient information leaflets about medicines provided to them in multi-compartment compliance packs.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for

unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day and recorded their findings. The temperature records were within acceptable limits. Pharmacy team members checked medicine expiry dates every three months, and they recorded these checks. They highlighted items due to expire in the next six months by attaching a sticker to the pack. And they removed expiring items during the check before their expiry. Pharmacy team members explained how they acted when they received a drug alert or manufacturers recalls. And they recorded how they acted in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains its equipment properly, so it is safe to use. And pharmacy team members manage and use the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. It also had reference resources available, including the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available to help prepare liquid medicines. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected.

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.